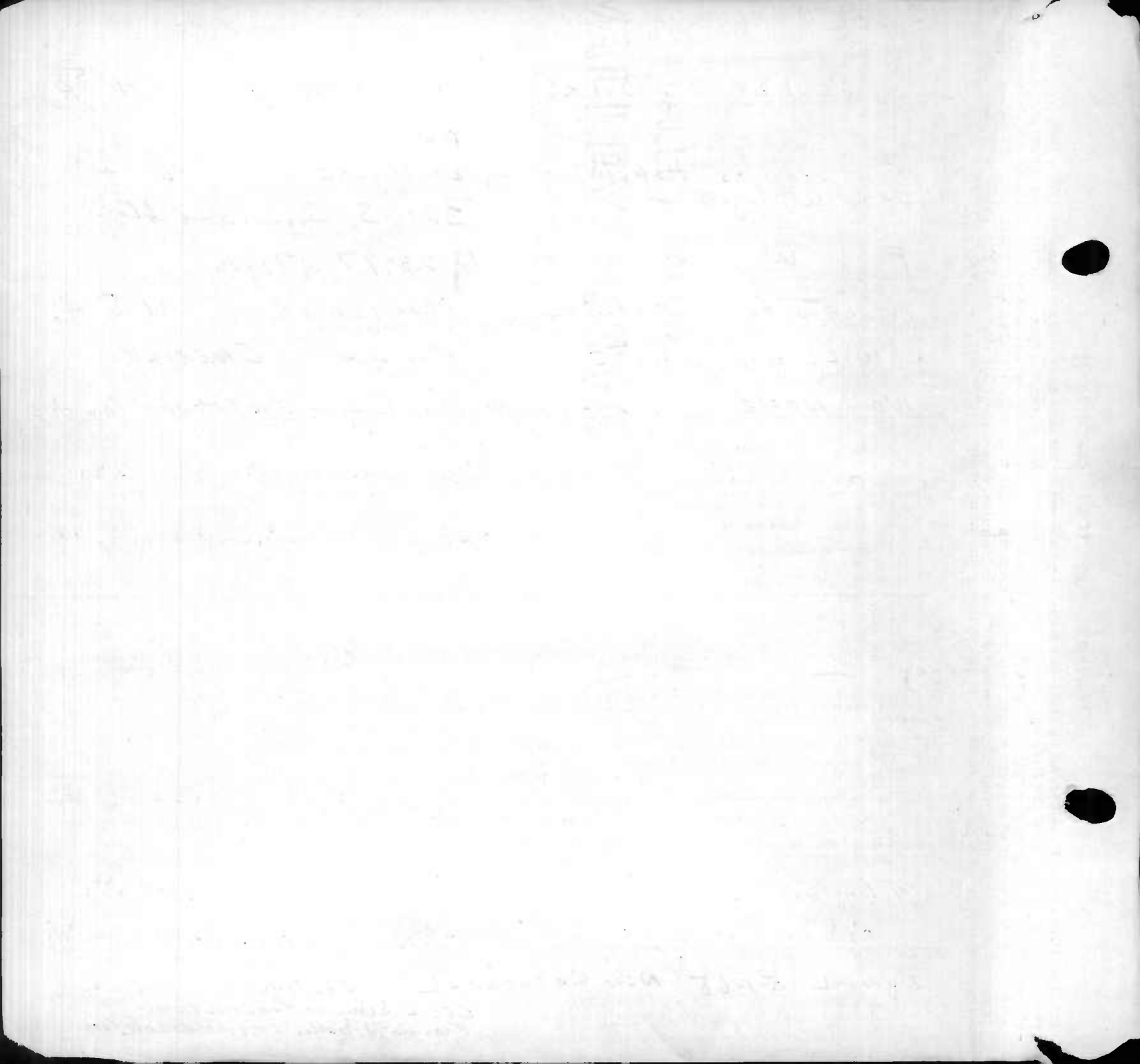


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200 68-4501				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4501	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Pauline L. Buck</b>		2. DATE AND HOUR OF DEATH <b>4-28-68 4:55 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>md.</b> B. COUNTY		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bon Secours Hospital 2025 W. Fayette St. 21223</b>				E. STREET AND NUMBER <b>321 S. Smallwood St.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-23-97 71 yrs</b>		9. AGE (In years last birthday)		10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William White</b>				14. MOTHER'S MAIDEN NAME <b>Emma Emerick</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NONE</b>			16. SOCIAL SECURITY NO. <b>212-12-7397D</b>		17. INFORMANT ADDRESS <b>Mary Linger 3007 Manhattan Ave.</b>		
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Ante Post Mortem Edema</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ante Post Mortem Edema</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>443X II</b>				(B) <b>Hypertensive Cardio Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2037</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) _____			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>8-14-1948</b> to <b>4-28-1968</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4-26-1968</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Wilmer K. Gallagher M.D.</b>				23B. DATE SIGNED <b>4-29-68</b>			
23C. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher M.D.</b>				23D. ADDRESS <b>6209 Frederick Ave, Baltimore, 28, Md.</b>			
24A. BURIAL CREMATION, REMOVAL? (Specify) <b>BURIAL</b>		24B. DATE <b>5-1-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>NEW CATHEDRAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>660 E. SCHWAB FUNERAL HOME Francis H. Miller 2101 Frederick Ave.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-640		68-4502		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4502	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>ROBERT C. HERRELL</b>			
2. DATE AND HOUR OF DEATH <b>APRIL 29, 1968 6:35 A.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours Hospital</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>1705 W. Lemmon Street</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-19-1899</b>		9. AGE (In years last birthday) <b>68</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				11. BIRTHPLACE (State or foreign country) <b>VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES HERRELL</b>				14. MOTHER'S MAIDEN NAME <b>MARIA SHUMAKER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MARY HERRELL</b>		ADDRESS <b>1705 LEMMON ST.</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cancer of (R) lung (possible primary)</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
162.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>(the)</del> <b>(this hospital)</b> attended the deceased from <b>4-20</b> 19 <b>68</b> to <b>4-29</b> 19 <b>68</b> , that <del>(he)</del> <b>(we)</b> last saw the deceased alive on <b>4-29</b> 19 <b>68</b> and that in <del>(my)</del> <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above <b>(I) (We) (did) (did not)</b> view the body after death.							
23A. SIGNATURE <b>M. Sarkarati</b>				23B. DATE SIGNED <b>4-29-68</b>			
23C. PHYSICIAN'S NAME (Type) <b>Mehdi Sarkarati</b>				23D. ADDRESS <b>Bon Secours Hospital, 2025 W. Fayette St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-2-67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN</b>		24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairburn</b>		25C. FUNERAL DIRECTOR <b>C. L. Schwab</b> <b>Francis H. Miller</b>			



1  
H-463

68- 4503 BALTIMORE CITY HEALTH DEPARTMENT

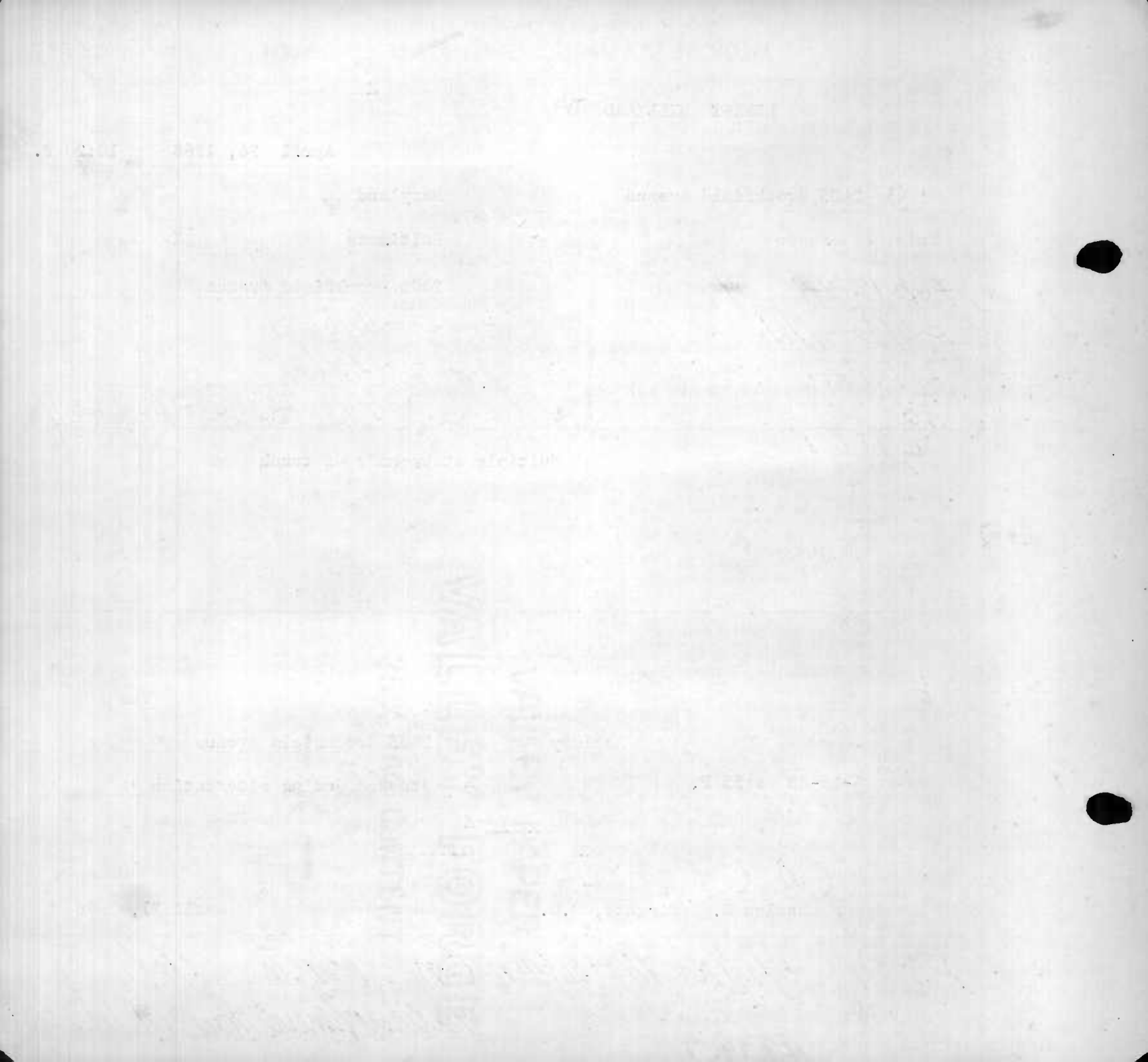
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4503

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ERNEST HILLIARD Jr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>April 26, 1968 10:20 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2405 Brookfield Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 26, 1968 10:20 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Feb. 17, 1949</b>	10. AGE (In years last birthday) <b>19</b>	E. STREET AND NUMBER <b>2405 Brookfield Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		15. MOTHER'S MAIDEN NAME <b>Alberta Balpen</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Ernest Hilliard Sr.</b>		ADDRESS <b>2405 Brookfield Ave</b>	
19. <b>E 966 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple stabwounds of trunk</b>		CAUSE OF DEATH <b>Multiple stabwounds of trunk</b>	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>hallway</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2405 Brookfield Avenue 13-01</b>		22F. HOW DID INJURY OCCUR? <b>Stabbed during altercation</b>	
22D. TIME OF INJURY (APPROX.) <b>4-26-68 9:55 P.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		DATE SIGNED <b>April 27, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/1/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>St. Luke's Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Tabor</b>	25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>	ADDRESS <b>319 N. Schroeder St.</b>



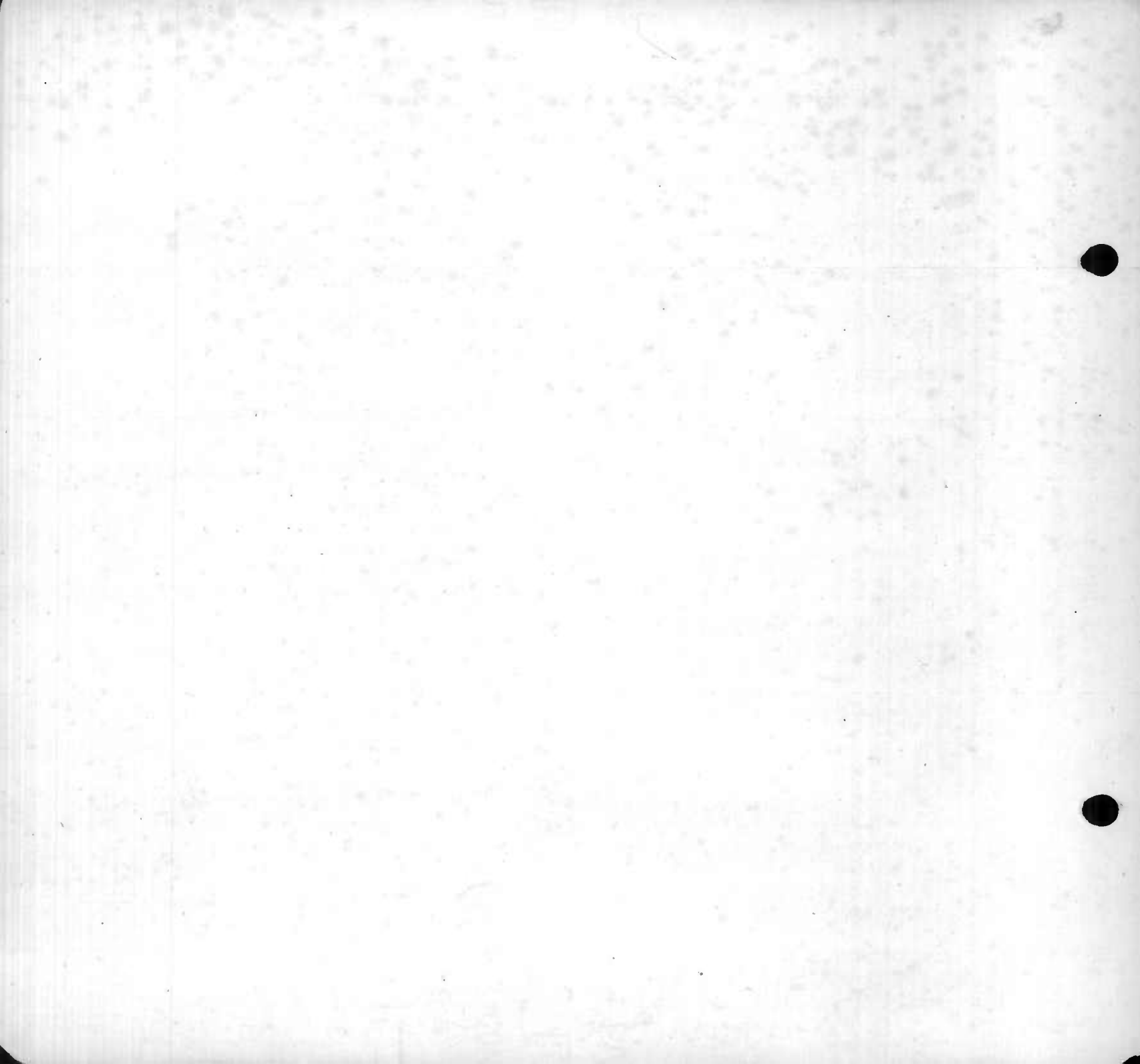
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 4504 CERTIFICATE OF DEATH

REG. NO. 68- 4504

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ADELE WOLMAN</b>		2. DATE AND HOUR OF DEATH <b>APRIL 27, 1968 2 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>6022 BERKELEY AVENUE</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BACTO</b> C. CITY OR TOWN <b>BACTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6022 BERKELEY AVE</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/12/1890</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ADOLPH</b>		14. MOTHER'S MAIDEN NAME <b>SOPHIE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS HERBERT HARRIS</b> ADDRESS <b>SAME</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Coronary Occlusion</b> (B) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>recomp.</b> (C) <b>Gen'l arteriosclerosis</b>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b> <b>1 yr.</b> <b>10 yrs.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 1968</b> to <b>Apr. 27, 1968</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>April 27, 1968</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> (did) <b>(did not)</b> view the body after death.					
23A. SIGNATURE <b>Lorestein</b> DEGREE				23B. DATE SIGNED <b>4/28/68</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/28/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO</b>	
24D. LOCATION (City, town, or county) <b>BACTO</b>		24E. STATE <b>MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son, Inc</b>		25D. ADDRESS <b>Garrison</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4505

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 4505

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Elmer Gordy Ruark</b>		2. DATE AND HOUR OF DEATH <b>April 24, 1968</b> <b>10: 25 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Dorchester Co. 59-00</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b> <b>3100 Wyman Pk. Drive</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Hoopersville</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>None</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/19/05</b> <b>12/02/06</b>	9. AGE (In years last birthday) <b>62</b> 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Captain</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Seafarer</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Fred Ruark</b>		14. MOTHER'S MAIDEN NAME <b>Lulu Meekins Meekins</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-16-8316</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>	
18. <b>154.1</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Wide spread metastases from adenocarcinoma of the rectum</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>21 mos.</b>	
18. <b>154 X</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>no</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Feb. 12</b> 1968 to <b>Apr. 24</b> 1968, that (1) (we) last saw the deceased alive on <b>Apr. 24</b> 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Henry S. Crist, M.D.</b>		23B. DATE SIGNED <b>4/25/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Henry S. Crist, SA Surg (R)</b>	
23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/27/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Dorchester Memorial Park</b>	
24D. LOCATION <b>Cambridge, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>LeCompte Funeral Service, Cambridge, Md.</b>	



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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-4506

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BESSIE D. BROPHY</b>		2. DATE AND HOUR OF DEATH <b>4-28-68 5:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>12-02</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7-28-96</b>		9. AGE (In years lost birthday) <b>71</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN JACKSON</b>		14. MOTHER'S MAIDEN NAME <del>UNKNOWN</del> <b>ALICE McMULLEN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-03-4922B</b>		17. INFORMANT <b>MRS. G. D. BENNER</b> ADDRESS <b>102 SCRIPPS AVE MARYLAND</b>	
18. <b>410.94 1250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>HEART FAILURE</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>B. MYOCARDIAL INFARCTION 3 days</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROTIC Cardiovascular 11 yrs</b> (C) <b>DIABETES MELLITUS 11 years</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>420.1 II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Specify)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-28-68</b> 19 to 19, that (I) (we) lost saw the deceased alive on <b>4-28</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <b>Marlene L. Haribao</b>		23B. DATE SIGNED <b>4-28-68</b>		23C. PHYSICIAN'S NAME (Type) <b>MARLENE L. HARI BAO M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE		24C. NAME of CEMETERY or CREMATORY <b>Parkwood</b>	
24D. LOCATION (City, town, or county) <b>Balto. Co.</b>		24E. STATE <b>Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>		25D. ADDRESS <b>6500 York Road Balto., Md. 21212</b>	

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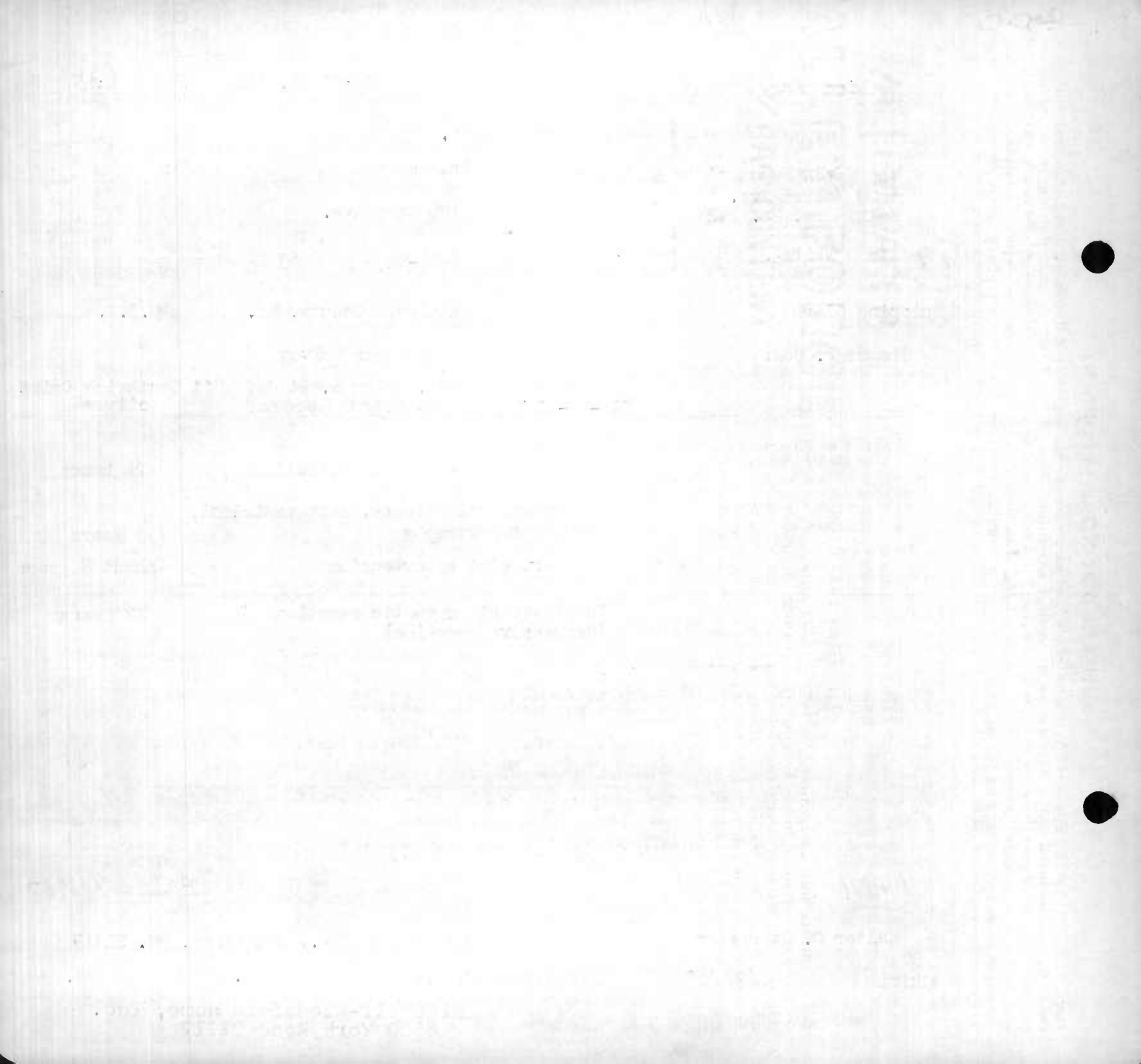
WARRAND

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 4507 CERTIFICATE OF DEATH

REG. NO. 68- 4507

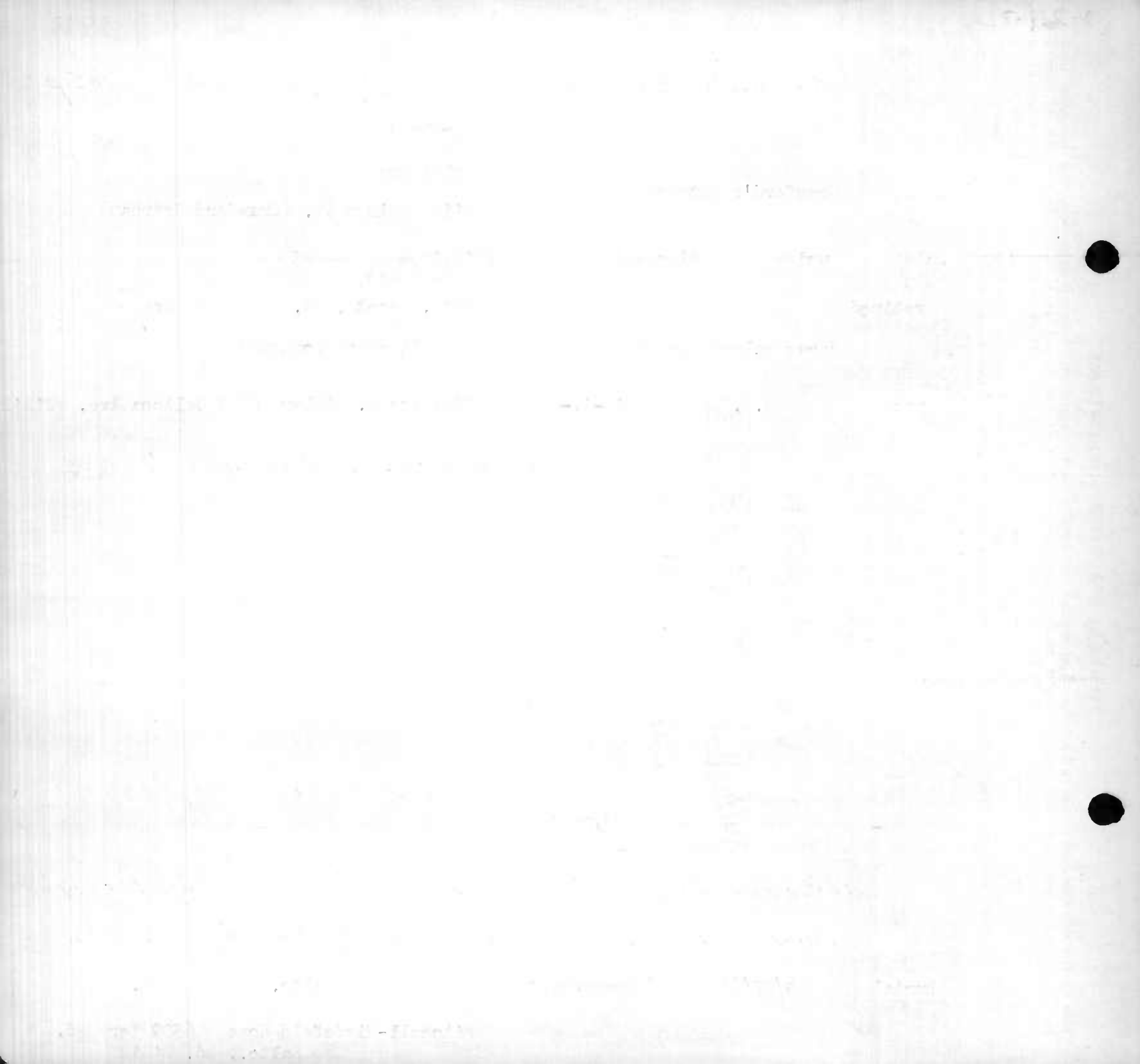
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Miss Mary Neary</b>		2. DATE AND HOUR OF DEATH <b>April 24, 1968 4:45 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>21 The Seton Psychiatric Institute 6400 Wabash Ave. Baltimore, Md. 21215</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>8-17-04</b>		9. AGE (In years last birthday) <b>63</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas F. Neary</b>	
14. MOTHER'S MAIDEN NAME <b>Catherine McEvoy</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-07-4361</b>	
17. INFORMANT <b>Mrs. Helen E. Kilduff 811 Southwick Drive Hospital Records</b>		ADDRESS <b>city #4</b>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.0 I</b>		(A) IMMEDIATE CAUSE <b>Coronary Infarction</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Disease, left ventricular, hypertrophy</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arterial hypertension</b>		<b>3 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Involuyional psychotic reaction (depressive reaction)</b>		(C) _____		<b>about 8 years</b>	
19A. DATE OF OPERATION <b>4 20.1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 14, 1956</b> to <b>April 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 24, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Walter O. Jahrreiss M.D.</b>				23B. DATE SIGNED <b>April 24, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>Walter O. Jahrreiss</b>		23D. ADDRESS <b>6400 Wabash Ave., Baltimore, Md. 21215</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/27/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cathedral Cemetery</b>	
24D. LOCATION <b>Balto.</b>		24E. STATE <b>Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>		25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b>		ADDRESS <b>6500 York Road 21212</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>68-4508</u>	
BIRTH NO. <u>68-4508</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MALCOLM DOUGLAS</u>		2. DATE AND HOUR OF DEATH <u>April 24, 1968 11:05 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>Crawford's Retreat</u> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2117 Denison St. (Crawford Retreat)</u>		
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>divorced</u>	8. DATE OF BIRTH <u>7/13/1892</u>	9. AGE (In years lost birthday) <u>75</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto. County, Md.</u>	
13. FATHER'S NAME <u>James Malcolm Douglas</u>			12. CITIZEN OF WHAT COUNTRY? <u>Usa</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.I</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Townsend</u>		
16. SOCIAL SECURITY NO. <u>214-12-9839</u>		17. INFORMANT ADDRESS <u>Elizabeth D. Miller 6302 Bellona Ave. #21212</u>			
18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic heart disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>7 years</u>			CAUSE OF DEATH (A) OUE TO (B) OUE TO (C)		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>420.0 II</u>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 4, 1961</u> to <u>April 24, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Abraham B. Hurwitz</u> M.O.				23B. DATE SIGNED <u>April 24, 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>ABRAHAM B. HURWITZ</u> M.O.				23D. ADDRESS <u>7501 Liberty Road, Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>4/27/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u>	
24D. LOCATION <u>Balto.</u>		24E. LOCATION <u>Balto.</u>		24F. LOCATION <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 30 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairburne</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4509 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 4509

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Carroll G. Kirby		April 25, 1968 5:05 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			MARYLAND		
208 RIDGEWOOD RD.			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 208 RIDGEWOOD ROAD		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1-Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	JAN. 15, 1902	66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
DIS'T TRAFFIC MGR. C & P TEL Co.				BALTIMORE MD.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOSEPH B. KIRBY			MARGARET CARROLL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
					MRS C. G. KIRBY 208 RIDGEWOOD ROAD
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
153.8 I		Cancer of colon			18 months
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
153.8 II		yes, in 1967, before my attendance began			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from Feb. 1 1968 to April 25 1968, that (I) (we) last saw the deceased alive on April 24 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
W.B. DANIELS, Jr. M.D.			4/25/68		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
W. B. DANIELS, Jr. M.D.			11 E. Chase St. Baltimore Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL	2/29/68	NEW CATHEDRAL CEMETERY		BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
APR 30 1968	Robert E. Fairbank	H.W. MEARS & SON 805 N. CALVERT ST.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4510	
1-462 68-4510				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Eleanor E Clank</u>		2. DATE AND HOUR OF DEATH <u>27 April 1968</u> <u>2 AM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore Co</u>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 Univ Hosp</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore 21227</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>5604 Huntsman Rd.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-17</u>	9. AGE (In years lost birthday) <u>50</u>	If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Arthur Viet</u>		14. MOTHER'S MAIDEN NAME <u>Marion Bigley</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hospital Record</u> ADDRESS	
18. 394.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiovascular Collapse</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral vascular Accident</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>410X II</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Mitral Valve Surgery for Mitral Stenosis</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>26 April</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Mitral Stenosis</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-24-68</u> 19 to <u>4-27-68</u> 19, that (I) (we) last saw the deceased alive on <u>4-27-68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C M Anderson MD</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>27 Ap '68</u>	
23C. PHYSICIAN'S NAME (Type) <u>C. M. Anderson, MD</u>		23D. ADDRESS <u>Univ. Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/1/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Landon Park Cem. Baltimore, Maryland</u>	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 30 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>		25C. FUNERAL DIRECTOR <u>Anderson &amp; Co. 1328 Sulphur Sp Rd.</u>	

Stone, W. J.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4511

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4511

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ANITA M. BLAIR</b> <i>BLAIR ANITA MISS</i>		2. DATE AND HOUR OF DEATH <b>APRIL 26, 1968</b> <i>4-26-68 3:55 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS HOSPITAL</b> <i>34 FAYETTE &amp; PHILADELPHIA ST BALTIMORE, MARYLAND</i>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>CITY</b> <i>Baltimore</i> <b>53-00</b>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		<b>RETIRED</b>		<b>BALTIMORE, MD</b>	
13. FATHER'S NAME <b>JOSEPH J. BLAIR</b>				14. MOTHER'S MAIDEN NAME <b>ROSE DORAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-32-0814</b>		17. INFORMANT ADDRESS <b>Anita F. Dell 11 Northwood Drive</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary Insufficiency</b> <b>Severe Arteriosclerotic C.V. Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/27</b> 19 <b>68</b> to <b>4/26/68</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/26/68</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>RENE O. SARTINO</b>				23B. DATE SIGNED <b>4/26/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>RENE O. SARTINO</b>		23D. ADDRESS <b>BON SECOURS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 30, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. (State) <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>RENE O. SARTINO</b>		25C. FUNERAL DIRECTOR'S ADDRESS <b>Sterling Funeral Estate</b> <b>736 Edmondson Ave.</b> <b>Catonville, Md. 21228</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4512

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-4512

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BONSALL, ELIZABETH ANNA		APRIL 28, 1968 8:25A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN Halethorpe D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX FEMALE			6. RACE WHITE		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 05/06/07		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY			10B. KIND OF BUSINESS OR INDUSTRY Hecht Company		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE HARTHAUSEN			14. MOTHER'S MAIDEN NAME MINNIE SCHOLL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 214-16-9444		
17. INFORMANT CATON & WILKENS AVES			ADDRESS		
18. 183.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic Cancer</i> (B) <i>of ovary &amp; shock</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from APRIL 16 19 68 to APRIL 28 19 68, that (I) (we) last saw the deceased alive on APRIL 28 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE <i>M. Nickbakht</i>			23B. DATE SIGNED 04/28/68		
23C. PHYSICIAN'S NAME (Type) M. NICKBAKHT MD			23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVES		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-1968		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION Howard County, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 30 1968		24F. NAME OF REGISTRAR <i>Robert E. Farley</i>	
24G. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		24H. ADDRESS 4107 Wilkens Ave. 21229		24I. DATE OF DEATH APR 28 1968	



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-4513
BIRTH NO. 67-26246		68-4513		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
WILLIAMS, JOSEPH PATRICK		APRIL 27, 1968 7:20A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229		A. STATE MARYLAND		
		B. COUNTY Balto Co 21228 53-00		
C. CITY OR TOWN <del>BALTIMORE</del> Arbutus		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		E. STREET AND NUMBER 5007 WILKENS AVE.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/67	9. AGE (In years lost birthday) 4 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME MORRIS WILLIAMS		14. MOTHER'S MAIDEN NAME MARY REUSCHLING		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT CATON & WILKENS ST. AGNES HOSP. RECORDS-BALTO. MD.
18. 759.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Multiple congenital defects DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
19. 759.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from APRIL 5 19 68 to APRIL 27 19 68, that (X) (we) last saw the deceased alive on APRIL 27 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.				
23A. SIGNATURE Marston A. Young M.D.		23B. DATE SIGNED 4/27/68		23C. PHYSICIAN'S NAME (Type) MARSTON A. YOUNG M. D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-30-1968		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR Hubbard Funeral Home, 4107 Wilkens Ave.		
25A. DATE REC'D BY HEALTH DEPT. APR 30 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. ADDRESS Hubbard Funeral Home, 4107 Wilkens Ave.

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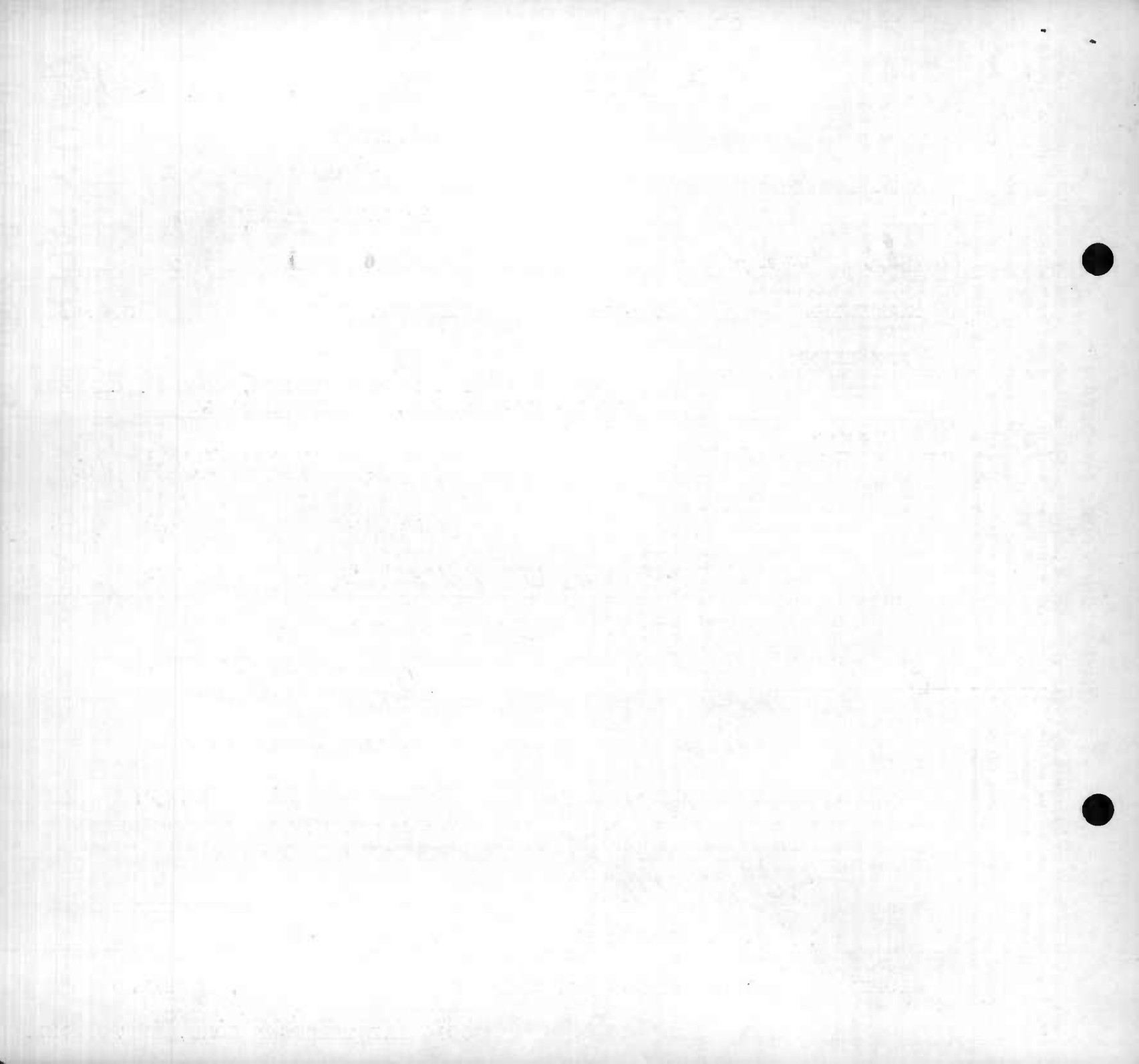
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

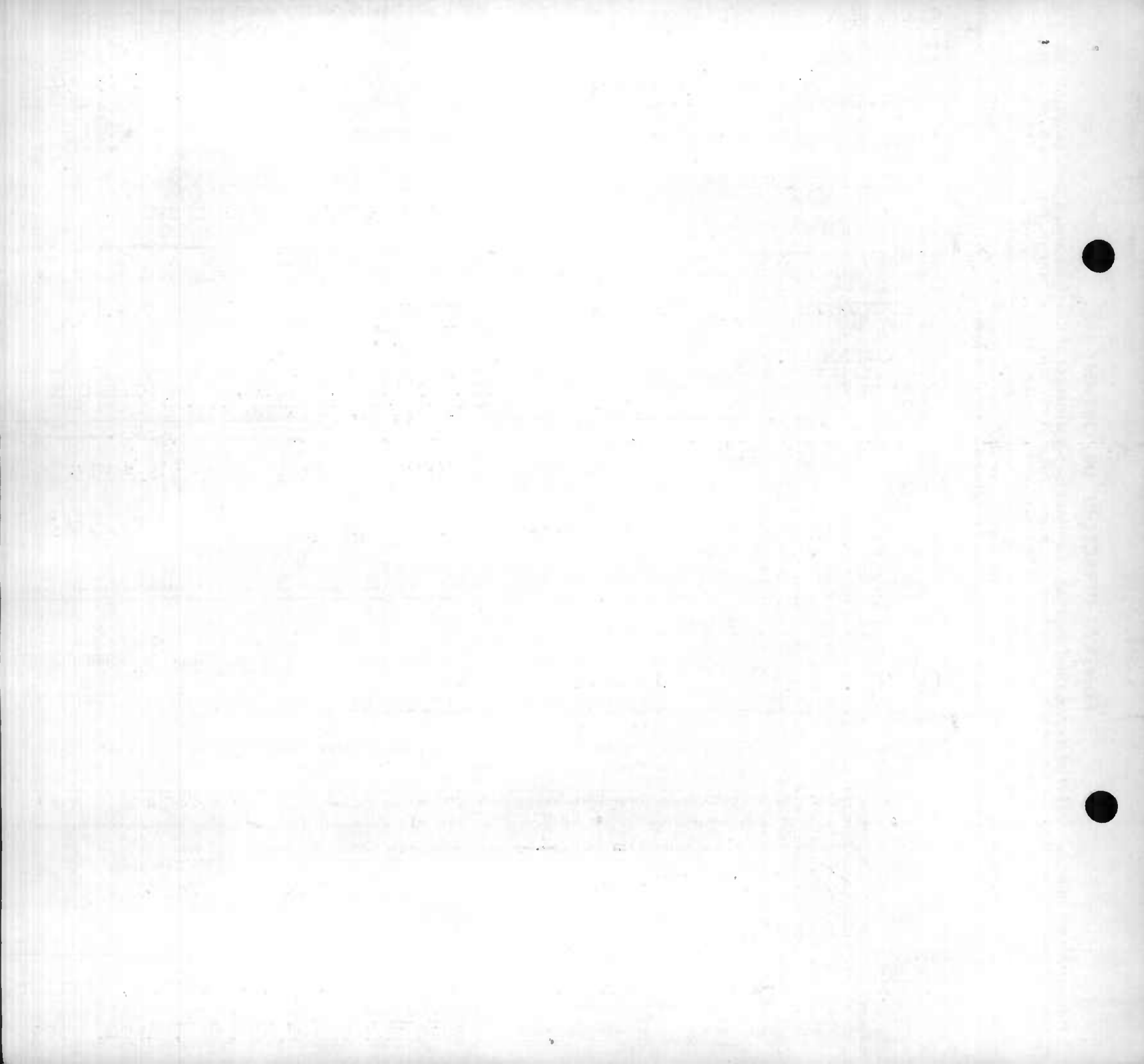
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4514	
68-4514 CERTIFICATE OF DEATH					
BIRTH NO. 5-430		1. NAME OF DECEASED (Type or Print) <i>Reba SALLON</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <i>4/26/68 6:15 A.M.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>SINAI HOSPITAL</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> C. CITY OR TOWN <i>BALTO</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>4812 REISTERSTOWN ROAD</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-30-1886</i>	9. AGE (In years last birthday) <i>81</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>MAX BERMAN</i>		14. MOTHER'S MAIDEN NAME <i>MARY ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214-16-9118</i>		17. INFORMANT ADDRESS <i>MRS. MARTHA MORROW, 4000 N. CHARLES STREET, BALTIMORE 21218</i>	
18. <i>430.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Subarachnoid hemorrhage 3 days</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Massive intracerebral &amp; subarachnoid hemorrhage 3 days</i> (C) <i>GT hemorrhage - hemorrhagic stroke 3 days</i>  <i>LLL pneumonia</i>			
19A. DATE OF OPERATION <i>330X II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/23</i> 19 <i>68</i> to <i>4/26</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/26</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. S. Glushakow</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>A. S. GLUSHAKOW</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4-28-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>JEHUDA AMACHBY LODGE</i>	
24D. LOCATION (City, town, or county) <i>ROSEDALE, MARYLAND</i>		24E. DATE REC'D BY HEALTH DEPT. <i>APR 30 1968</i>		24F. NAME OF REGISTRAR <i>Robert E. Farkas</i>	
24G. DATE REC'D BY HEALTH DEPT. <i>APR 30 1968</i>		24H. NAME OF REGISTRAR <i>Robert E. Farkas</i>		24I. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN ROAD, BALTO. 21215</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-645				68-4515		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4515	
1. NAME OF DECEASED (Type or Print) <u>SARAH SIEULNICK</u>				2. DATE AND HOUR OF DEATH <u>4/26/68</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>230 A</u> M.			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>53-00</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>FEMALE</u>				6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>71</u>	
9. AGE (In years lost birthday) <u>71</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAHAM TAPPER</u>				14. MOTHER'S MAIDEN NAME <u>IDA ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>215-01-0022</u>				17. INFORMANT <u>MR. SAMUEL SIRULNIK, 6934 MILBROOK PARK DRIVE, BALTIMORE 21215</u>				ADDRESS	
18. <u>570X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>UREMIA</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HEPATITIS CHRONIC &amp; ACUTE</u> (B) DUE TO, OR AS A CONSEQUENCE OF:				3 MONTHS					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>580X II</u>									
19A. DATE OF OPERATION <u>02/29/68</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>JAUNDICE</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>15 APRIL 19 68</u> to <u>26 APRIL 19 68</u> , that (2) (we) last saw the deceased alive on <u>26 APRIL 19 68</u> and that in (my) ( ) opinion death occurred on the date and hour and from the causes stated above. (I) ( ) (did) ( ) view the body after death.									
23A. SIGNATURE <u>Barry M. Potter M.D.</u>				23B. DATE SIGNED <u>26 APRIL 68</u>		23C. PHYSICIAN'S NAME (Type) <u>BARRY M. POTTER, M.D.</u>			
23D. ADDRESS <u>SINAI HOSP</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					
24B. DATE <u>4-28-68</u>				24C. NAME OF CEMETERY or CREMATORY <u>KNESSETH ISRAEL ANSHE KOLK WOLYN, BALTIMORE, MARYLAND</u>				24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 30 1968</u>				25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC.</u>			
						ADDRESS <u>6010 REISTERSTOWN ROAD, BALTO. 21215</u>			

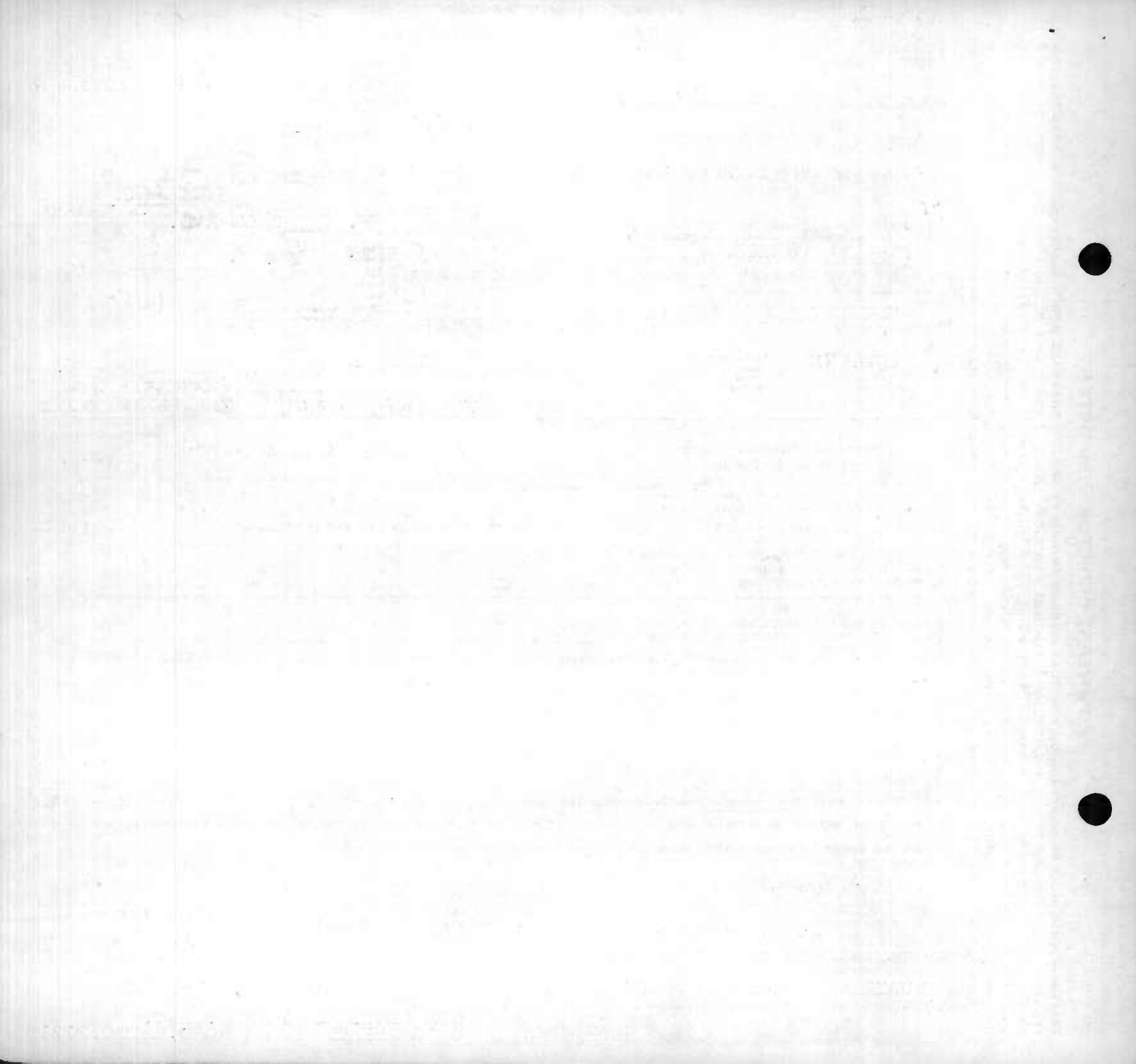




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

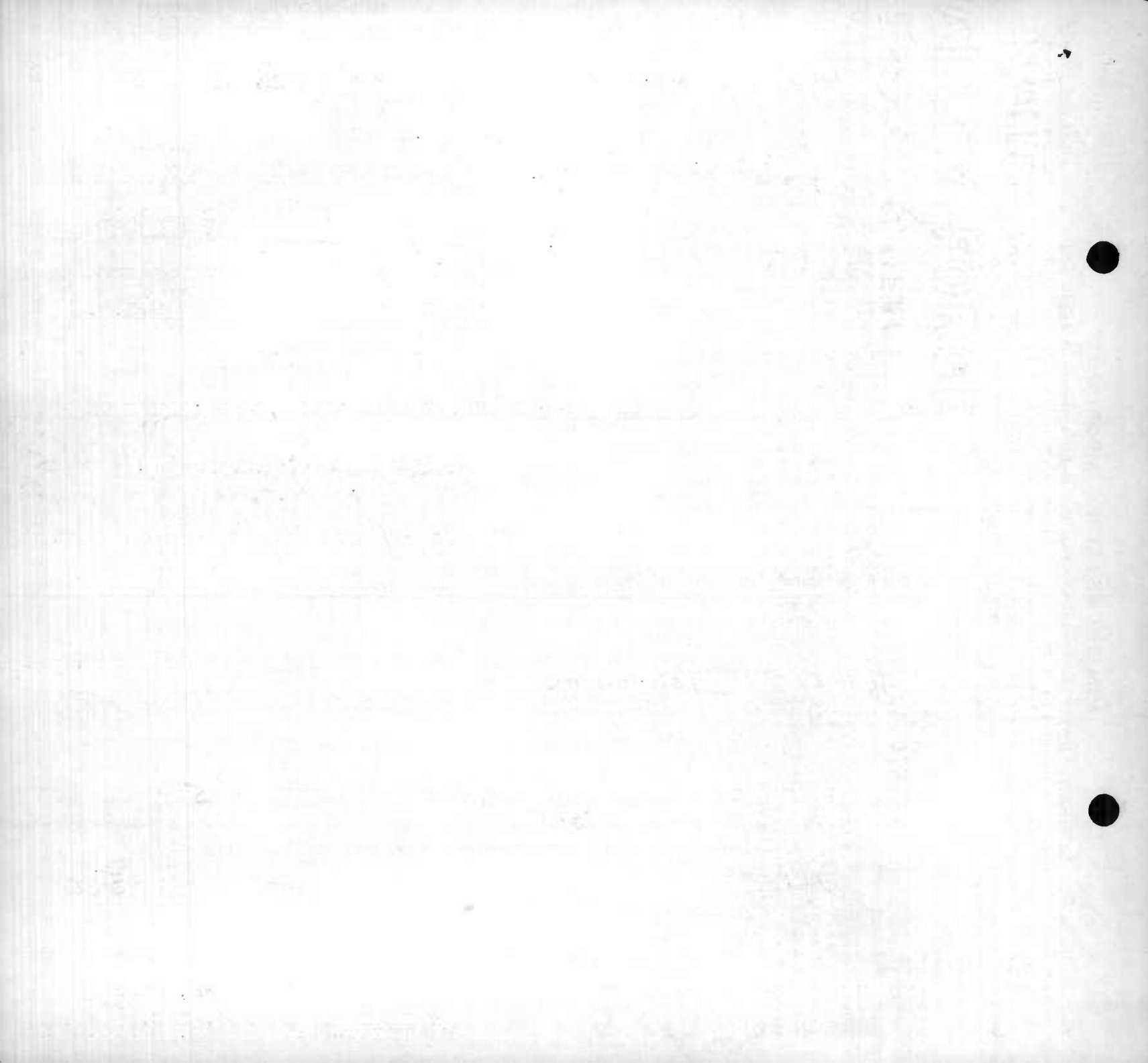
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4516</b>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>ROSA WACHS</b>		<b>68-4516 CERTIFICATE OF DEATH</b> <b>2. DATE AND HOUR OF DEATH</b> <b>APRIL 26, 1968 12:30 P.M.</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LEVINDALE HEBREW HOME &amp; INFIRMARY</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> <b>5. CITY OR TOWN</b> <b>Baltimore</b> <b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>7. STREET AND NUMBER</b> <b>3524 W. GARRISON AVE.</b>		
<b>5. SEX</b> <b>FEMALE</b>	<b>6. RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5-15-1887</b> <b>9. AGE</b> (In years lost birthday) <b>80</b> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Rumania</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>(USA)</b>	
<b>13. FATHER'S NAME</b> <b>UNKNOWN</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>UNKNOWN</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>2700 SULGRAVE AVENUE #15</b> <b>MR. ADOLPH WACHS</b>		
<b>18. 199.1 I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <b>Due to, or as a consequence of:</b> <b>Hypertatic Bronchopneumonia</b> <b>(B) Metastatic Carcinoma</b> <b>Due to, or as a consequence of:</b> <b>(C)</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 days</b> <b>1 year</b>
<b>199.2 II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <b>0</b>	<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>NO</b>	<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>	<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)	<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 3-16-1967 to 4-26-1968, that (I) (we) last saw the deceased alive on 4-26-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <b>Ardaiz</b>		<b>23B. DATE SIGNED</b> <b>4-26-68</b>		<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Jose ARDAIZ, MD</b>
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>24B. DATE</b> <b>4-28-68</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>OHEL YAKOV</b>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>APR 30 1968</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Farber</b>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> <b>SOL LEVINSON &amp; BROS. INC.</b> <b>6010 REISTERSTOWN ROAD, BALTO. 21215</b>
<b>24D. LOCATION</b> (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-620		68-4517		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4517	
1. NAME OF DECEASED (Type or Print) <b>MYERS, MOLIE.</b>				2. DATE AND HOUR OF DEATH <b>4/25/68 8:15 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>42</b> <b>SINAI HOSPITAL of BALTO</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3403 LABYRINTH ROAD #21215</b>							
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 18, 1906</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN GLASSMAN</b>				14. MOTHER'S MAIDEN NAME <b>MARY ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-46-0850</b>		17. INFORMANT <b>MR. ISRAEL MYERS, 3403 LABYRINTH RD.</b>			
18. <b>199.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>199.2 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Peritonitis and sepsis.</b> (B) DUE TO, OR AS A CONSEQUENCE OF <b>due to inflammation of Carcinoma</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4/2-4/25/68</b>	
19A. DATE OF OPERATION <b>4/14/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PERITONITIS</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/26/68</b> 19 to <b>4/26/68</b> 19 that (I) (we) last saw the deceased alive on <b>4/25/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>B. ETTINGER</b>				23B. DATE SIGNED <b>4/26/68</b>		23C. PHYSICIAN'S NAME (Type) <b>B. ETTINGER</b>	
23D. ADDRESS <b>SINAI HOSPITAL</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-28-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH EL</b>		24D. LOCATION (City, town, or county) (State) <b>RANDALLSTOWN, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD, BALTO. 21215</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 4518	
L-120 68- 4518		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>JANICE A. LUBICH</b>		4/26/68 3:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>425 SINAI HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>3400 GLEN AVE #21215</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/3/22</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	9. AGE (In years last birthday) <b>46</b>
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ABRAHAM LEVENTHAL</b>		14. MOTHER'S MAIDEN NAME <b>LENA MILLER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MR. LEONARD H. LUBICH</b>		ADDRESS <b>3400 GLEN AVENUE, BALTO. 21215</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of breast with widespread bony metastases</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>170X II</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. HOW DID INJURY OCCUR?	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/25/68</b> to <b>4/26/68</b> , that (I) (we) last saw the deceased alive on <b>4/26/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Joseph Gimbel</b>		23B. DATE SIGNED <b>4/26/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH GIMBEL</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-28-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>JEWISH WAR VETERANS MEMORIAL</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD, BALTO. 21215</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 4519

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>SAM J. STARKS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 28, 1968</b> Hour <b>12:30 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 28, 1968 12:30 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10-28-30</b>		10. AGE (In years lost birthday) <b>37</b>	
11. BIRTHPLACE (State or foreign country) <b>Fairfield Co., S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAM STARKS, SR.</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>16-04</b>	
15. MOTHER'S MAIDEN NAME <b>Maggie Hollis</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>251-40-3678</b>		18. INFORMANT ADDRESS <b>Mr. Walter Starks 217 N. Monroe St.</b>	
19. CAUSE OF DEATH <b>492X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cor Pulmonale due to Emphysema and Pulmonary Thrombo-Embolism</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Myocarditis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>5-27-61</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>	
21. AUTOPSY? (Yes or No) <b>No</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) (Minute) <b>22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></b>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4/29/68</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-2-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Moriah Ch. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Jenkinsville, S.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	



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1985-1986

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

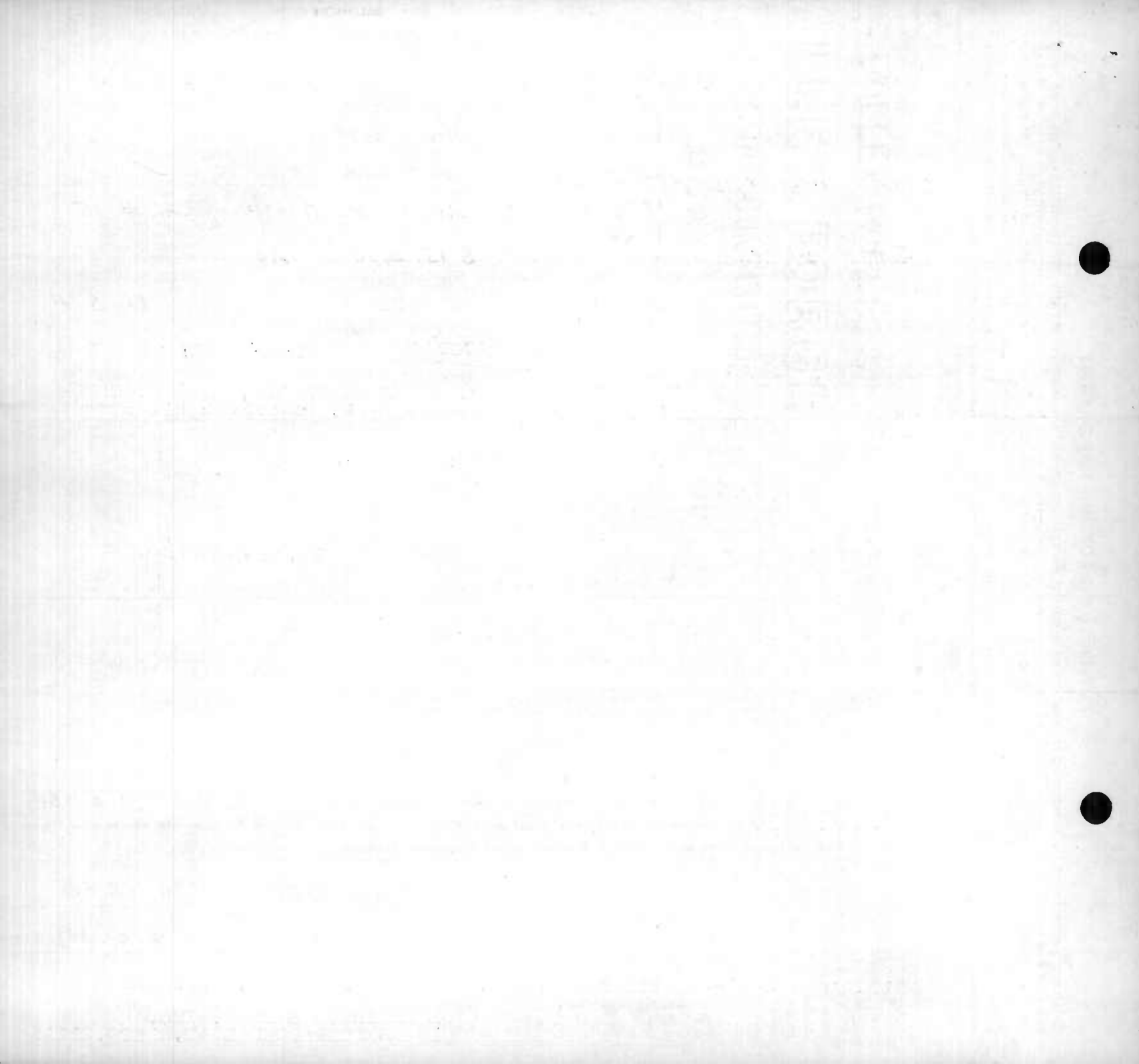
Baltimore City Health Department				REG. NO. 68-4520	
<div style="display: flex; justify-content: space-between;"> <span>2-635 68-4520</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HARRY M. ZERDEN</b>		2. DATE AND HOUR OF DEATH <b>April 26, 1968 5 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Jewish Convalescent Home</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4600 Pall Mall Rd.</b>		C. CITY OR TOWN <b>Baltimore</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
				E. STREET AND NUMBER <b>4601 PALL MALL ROAD</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>79</b>	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MERCHANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>LADIES CLOTHING</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
13. FATHER'S NAME <b>UNKNOWN</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>6819 216-56-1881</b>		17. INFORMANT <b>MR. DANIEL ZERDEN, 3301 TIMBERFIELD LANE</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Carcinoma of lung</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>one year</b>	
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1966 4/26</b> to <b>4/26 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>D. W. STEWART</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4/26/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>D. W. STEWART, M.D.</b>		23D. ADDRESS <b>3414 DUVAL AVENUE #21216</b> <del>FARM MARI NURSING HOME</del>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-28-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>(AITZ CHAIM) ANSHE EMUNAH, BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairley, M.D.</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b> <b>6010 REISTERSTOWN ROAD, BALTO. 21215</b>	

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

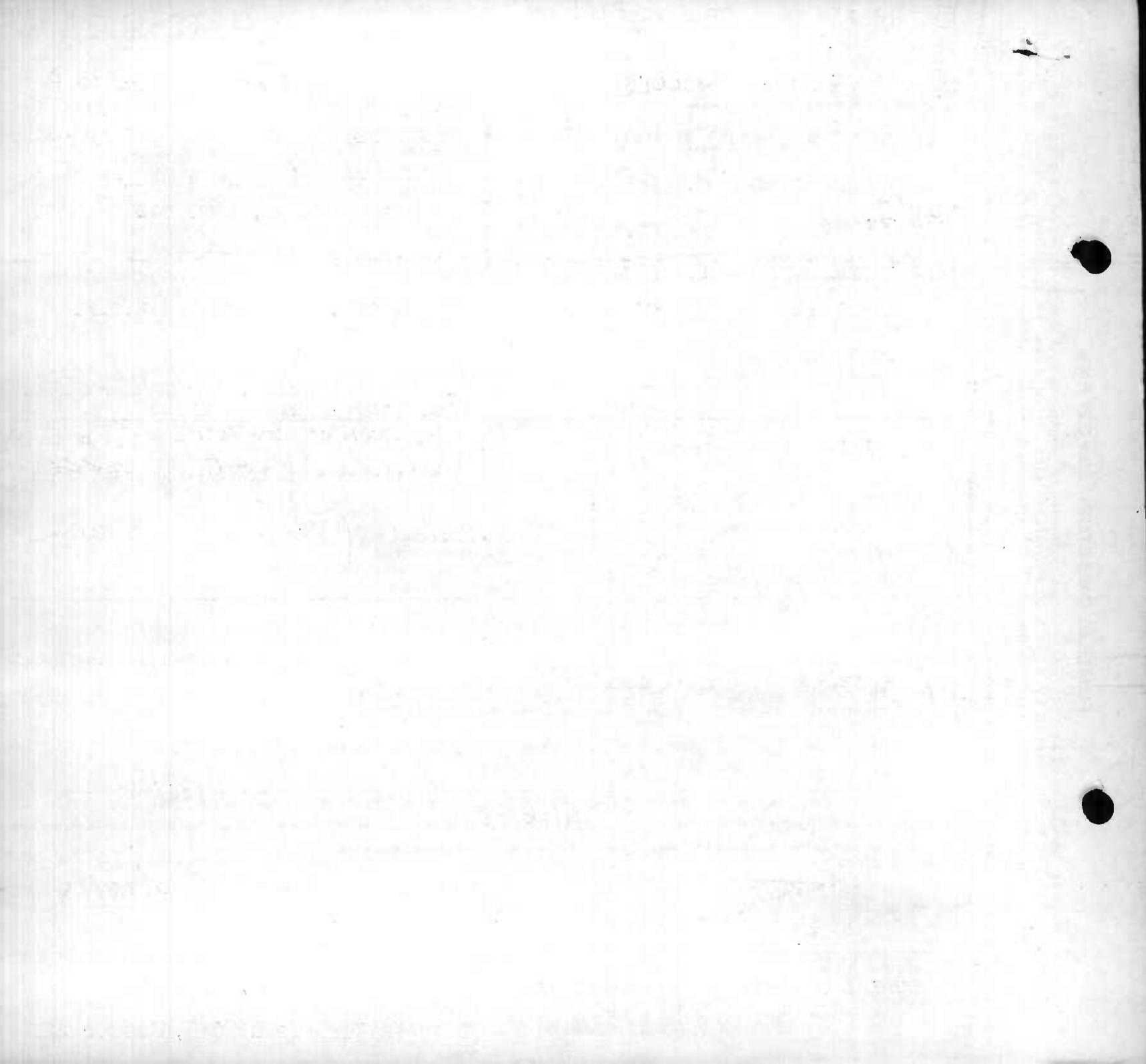
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 4521
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>BIRENBAUM, IRENE</b>		<b>4.26.68 at 8.15 PM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTO. MARYLAND</b>			A. STATE <b>Maryland</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>4031 W- Coldspring LA. # 15</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8.15.1920</b>	9. AGE (In years lost birthday) <b>48</b>	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>NATHAN GERSTT</b>			14. MOTHER'S MAIDEN NAME <del>XXXXXXXX</del> <b>DEVORAH ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. DAVID BIRENBAUM, 4031 W. COLD-SPRING LANE, BALTIMORE 21215</b>	
18. <b>410.9 + 1250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial infarction</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiovascular</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes Mellitus</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiovascular</b>		
(C) <b>Atherosclerotic disease</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>4.20.1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4.26.68</b> 19 to <b>8.15 PM, 4.26.1968</b> , that (I) (we) last saw the deceased alive on <b>4.26.68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <b>Speed</b>				23B. DATE SIGNED <b>4.26.68</b>	
23C. PHYSICIAN'S NAME (Type)  <b>Speed</b>				23D. ADDRESS <b>SINAI HOSPITAL OF BALTO. MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-28-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>RUDOMER VEREIN</b>	
24D. LOCATION (City, town, or county) <b>ROSEDALE, MARYLAND</b>		24E. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. ADDRESS <b>6010 REISTERSTOWN ROAD, BALTO. 21215</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4522	
1. NAME OF DECEASED (Type or Print) <b>EPSTEIN Mollie</b>		2. DATE AND HOUR OF DEATH <b>4/26/68</b> <b>10:20 P.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>53-00</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b> <b>42</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-15-1904</b> 9. AGE (In years last birthday) <b>64</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
13. FATHER'S NAME <b>MAYER CAPLAN</b>		14. MOTHER'S MAIDEN NAME <b>IDA ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. SAMUEL EPSTEIN, 11 SLADE AVENUE, APT. 716, BALTIMORE 21208</b> ADDRESS	
18. <b>1541</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY EMBOLUS</b> <b>Consequence of Rector</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Consequence of Rector</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>3 weeks</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>154X II</b>		(C).....			
19A. DATE OF OPERATION <b>4/26/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca of Rector / PULMONARY EMBOLUS</b>		20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>4/26/68</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>4/26/68</b> 19 to <b>4/26/68</b> 19, that (I) (we) last saw the deceased alive on <b>4/26/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>B. ETTINGER</b>		23B. DATE SIGNED <b>4/26/68</b>		23C. PHYSICIAN'S NAME (Type) <b>B. ETTINGER</b> 23D. ADDRESS <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-28-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>SHAAREI ZION</b> 24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b> ADDRESS <b>6010 REISTERSTOWN ROAD, BALTO. 21215</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4523	
<div style="display: flex; justify-content: space-between;"> <span>68-4523</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN F. FORD</b>		2. DATE AND HOUR OF DEATH <b>APRIL 27 - 1968</b> <span style="float: right;">3<sup>00</sup> PM</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>FRANKLIN SQUARE HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>4117 MORRISON CT. 21226</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 24, 1889</b>	9. AGE (In years lost birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>DAVIDSON CHEM Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>FORD</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>717-07-9989A</b>		17. INFORMANT <b>FAMILY</b>
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY ARTERY DISEASE</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIO SCLEROTIC C.F. DISEASE</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>			(B) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 1956</b> to <b>April 27 1968</b> , that (I) (we) last saw the deceased alive on <b>3/7/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sidney R. Gehlert</b>				23B. DATE SIGNED <b>4/29/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Sidney R. Gehlert</b>				23D. ADDRESS <b>4700 Pennington Ave. 21226</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>MAY 1-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>GLEN HAVEN CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>John H. HAHN Funeral Home, 4200 Pennington Ave</b>			

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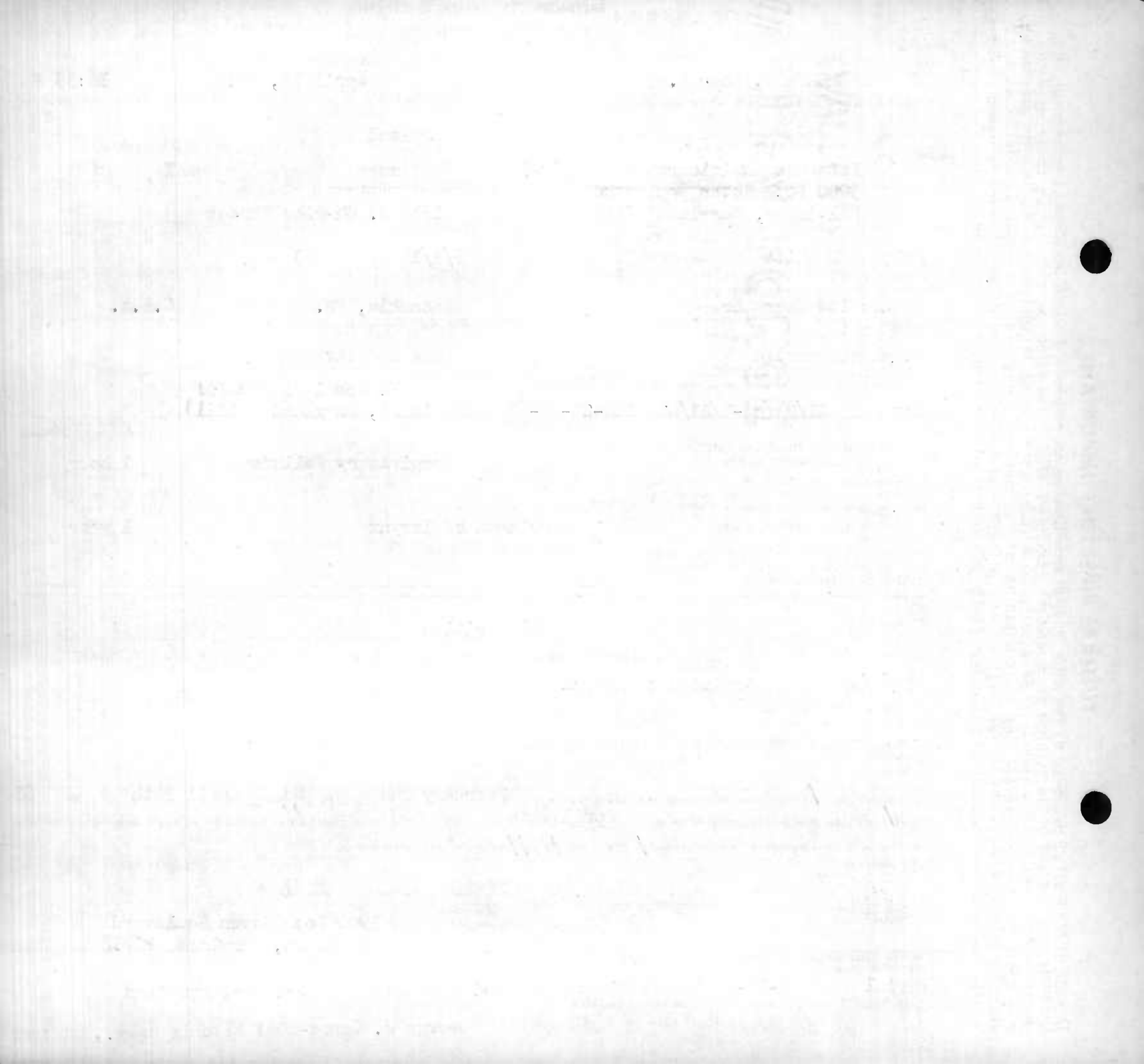
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FUNERAL DIRECTOR: IMPORTANT

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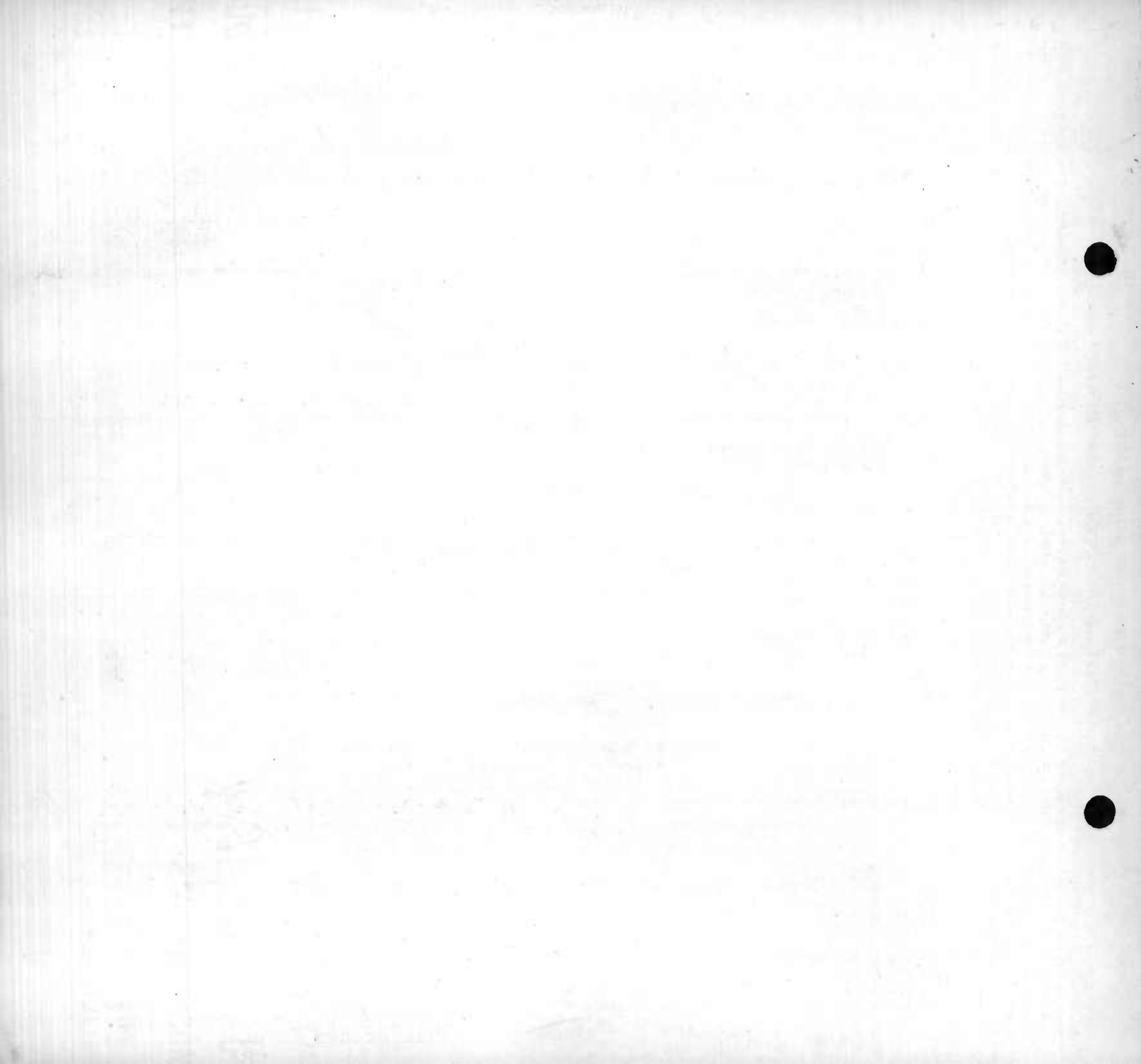
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68- 4524</span>	
68- 4524				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>NIEMCAVAGE, Leon E.</b>		2. DATE AND HOUR OF DEATH <b>April 24, 1968</b> <span style="float: right;"><b>10:35 P M.</b></span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> <b>12-06</b> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>5/1/14</b>	
13. FATHER'S NAME <b>Joseph Niemcavage</b>		14. MOTHER'S MAIDEN NAME <b>Anna Stancavage</b>		9. AGE (In years last birthday) <b>53</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 11/23/38-5/27/46</b>		16. SOCIAL SECURITY NO. <b>114-22-99-53</b>		11. BIRTHPLACE (State or foreign country) <b>Shamokin, Pa.</b>	
17. INFORMANT <b>VA Hospital Records</b>		ADDRESS <b>Baltimore, Maryland 21218</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. <b>1619 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenea, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>161X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Malnutrition</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
				19. DATE OF OPERATION <b>12/8/67</b>	
19A. DATE OF OPERATION <b>12/8/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of larynx</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>February 2nd</b> 19 <b>68</b> to <b>April 24th</b> 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>April 24th</b> 19 <b>68</b> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Victor Meloni Jon Bryson</i> DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		23D. ADDRESS <b>Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-29-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <b>George J. Gonce-4001 Ritchie Hgwy., Baltimore</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4525
BIRTH NO. 68-67879		68-4525 <b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>Deanna Marie Cimino</u>		2. DATE AND HOUR OF DEATH <u>4-28-68</u> <u>11 23</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Md.</u>		C. CITY OR TOWN <u>Baltimore</u>	D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2705 Edison Highway</u>				
5. SEX <u>F</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-28-68</u>	9. AGE (In years last birthday) <u>Newborn</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (State or foreign country) <u>Baltimore Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>42</u>
13. FATHER'S NAME <u>Michael Angelo Cimino</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Lillian Brush</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Michael Cimino, father, above</u>	
18. <u>770.1</u> I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Immaturity + Abruptio Placenta</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>761.5 II</u>				
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>11 55 AM 4-28-68</u> to <u>12 37 PM 4-28-68</u> . that (I) (we) last saw the deceased alive on <u>12 37 PM 4-28-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Farynfar M.D. 006</u>		23B. DATE SIGNED <u>4-28-68</u>		
23C. PHYSICIAN'S NAME (Type) <u>M-R. FARZANFAR M.D.</u>		23D. ADDRESS <u>2504 W. Patapsco Ave</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/29/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR <u>Robert E. Farber</u>	25C. FUNERAL DIRECTOR ADDRESS <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>		



68- 4526

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4526

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JACOB FREDERICK JACOB IHLE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 27, 1968 6:41 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>8/12/1917</b>		10. AGE (In years last birthday) <b>50</b>	
11. BIRTHPLACE (State or foreign country) <b>Smallwood, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant-Collins</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>	
15. MOTHER'S MAIDEN NAME <b>Mary E. Seller</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>213-05-7306</b>		18. INFORMANT <b>Barbara Baker Ihle, wife, above</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/1/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Nat. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>	



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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4527	
68-4527				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DERUTHEA ZORBACH, RUTH Estelle</b>		2. DATE AND HOUR OF DEATH <b>April 26, 1968 12:45 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Sinai Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3200 LAKE AVE #13</b>		
5. SEX <b>F</b>	6. RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/6/09</b>	9. AGE (In years last birthday) <b>59</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Read Drug &amp; Chem. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>William R. Klages</b>			14. MOTHER'S MAIDEN NAME <b>Laura Seth</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>212-07-8104</b>		16. SOCIAL SECURITY NO. <b>212-07-8104</b>		17. INFORMANT <b>Anthony Zorbach, husband, above</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>577.91x250.1</b> <b>HEPATIC FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CIRRHOSIS OF LIVER</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>3-81.0 II Acute cholecystitis; Diabetes</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>		
19A. DATE OF OPERATION <b>April 4, 1968</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gallstones</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 31 1968</b> to <b>April 26 1968</b> , that (I) (we) last saw the deceased alive on <b>April 26 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S.K. Chung</b>			23B. DATE SIGNED <b>April 26, 1968</b>		
23C. PHYSICIAN'S NAME (Type) <b>S. K. CHUNG M.B., B.S.</b>			23D. ADDRESS <b>Sinai Hospital of Baltimore</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/29/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>	
				ADDRESS <b>3331 Brehms Lane</b>	

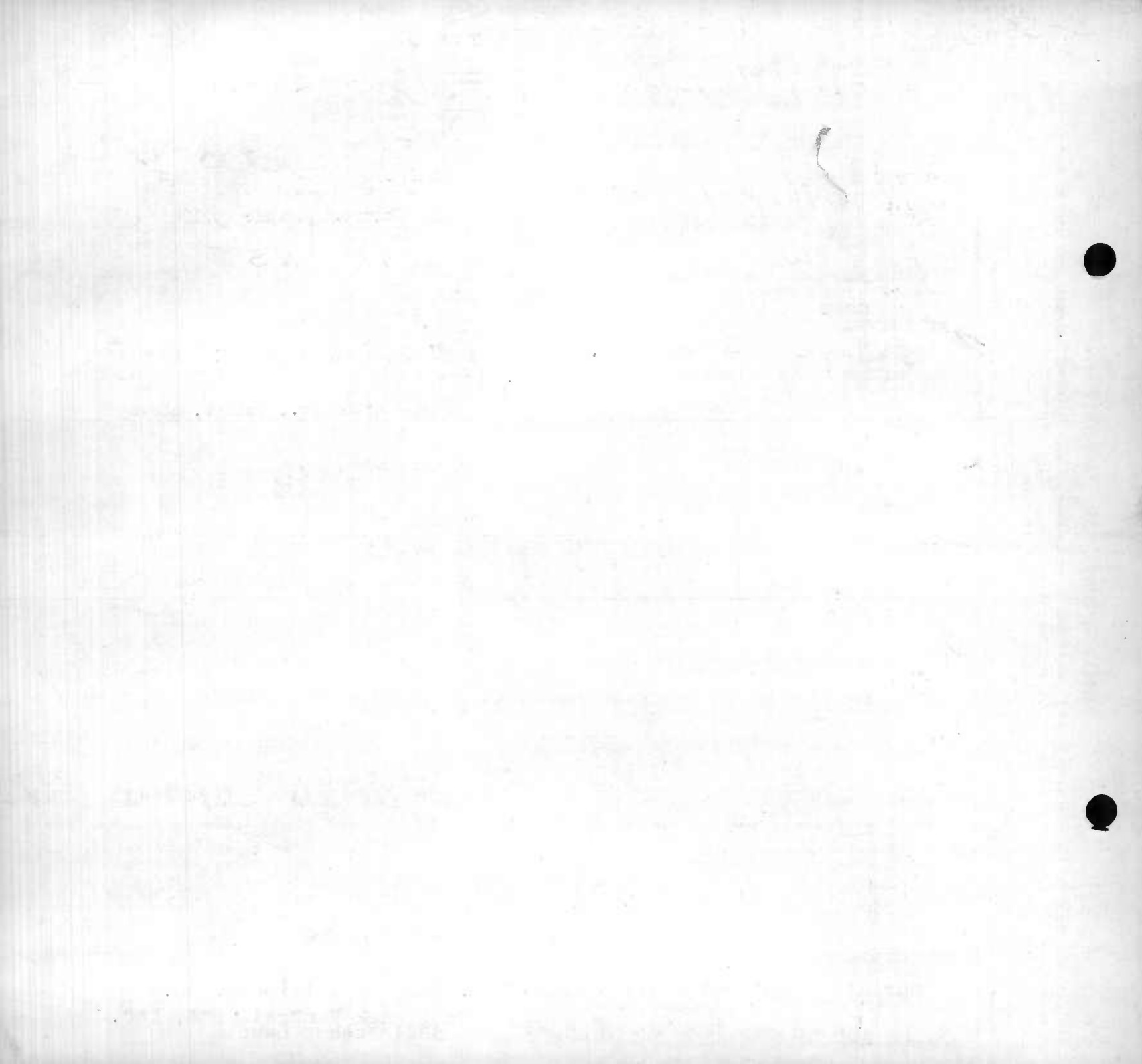
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO. 68-4528

BIRTH NO. 68-08084		68-4528		REG. NO. 68-4528	
1. NAME OF DECEASED (Type or Print) <b>Baby Mary Simon</b>			2. DATE AND HOUR OF DEATH <b>4-28-68 1:52 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 MERCY Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4514 Shamrock Avenue 21206</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-28-68</b>	9. AGE (In years last birthday) <b>NB</b>	If Under 1 Yr. Months: Days: Hours: Min. <b>44</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>George Simon Jr.</b>			14. MOTHER'S MAIDEN NAME <b>Geraldine M. Dentz</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>George Simon Jr., Father, above</b>	
18. <b>740X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Anencephaly</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. <b>750X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 28 1:08pm 1968</b> to <b>April 28 1:52pm 1968</b> , that (I) (we) last saw the deceased alive on <b>April 28 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marie Ann M.D.</b>				23B. DATE SIGNED <b>4/28/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARIA QUE, M.D.</b>				23D. ADDRESS <b>MERCY HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/29/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Mem. Park</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR <b>Robert E. Farkner</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>	
25D. ADDRESS <b>3331 Brehms Lane</b>		25E. ADDRESS		25F. ADDRESS	

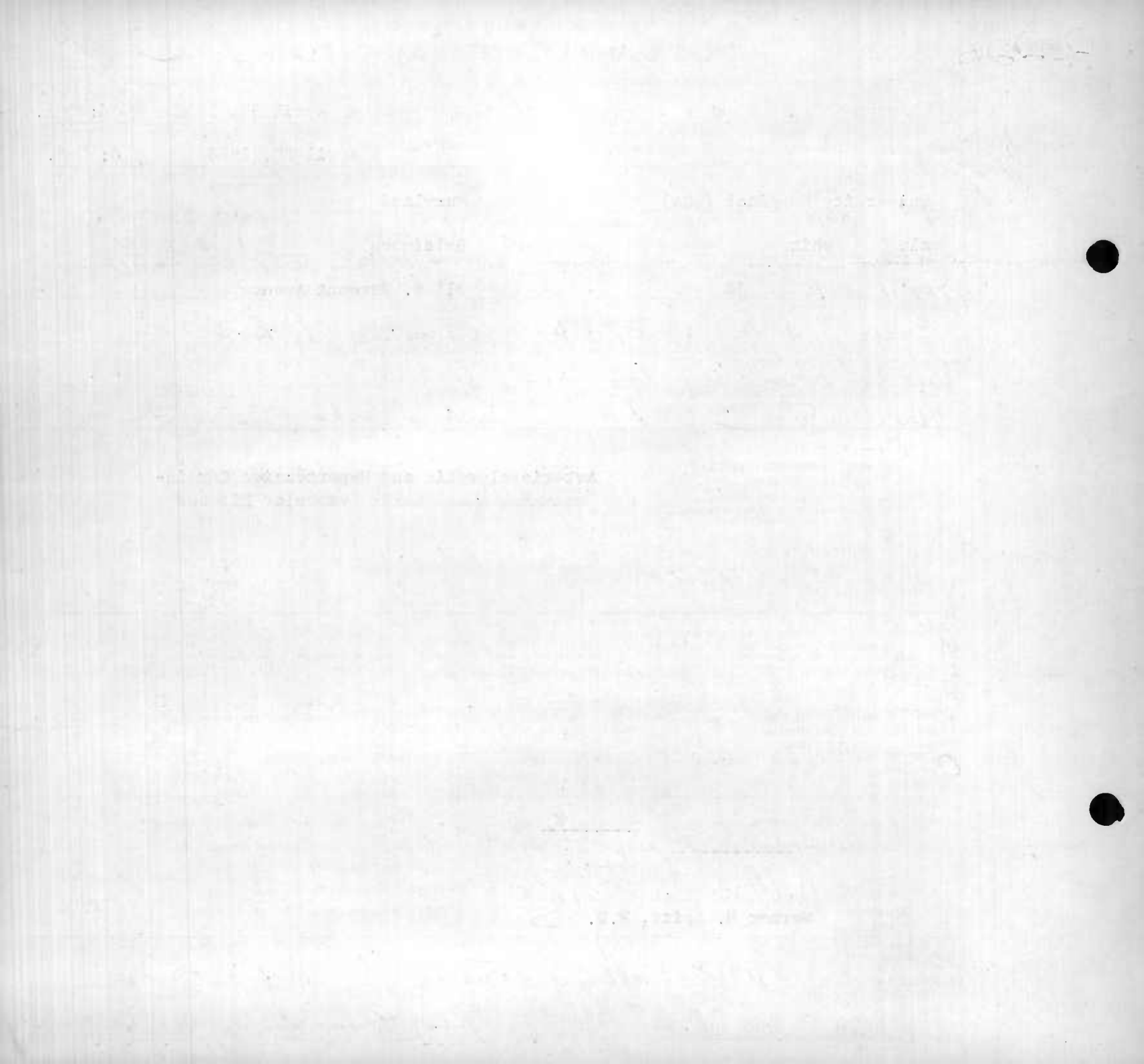


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>FREDERICK B. ROKOS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 29, 1968</b> Hour <b>6:40 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 29, 1968 6:40 A.M.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Jan 1, 1910</b>		10. AGE (In years last birthday) <b>58</b>	
11. BIRTHPLACE (State or foreign country) <b>Balti. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mech Worker</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Revere Copper Brass</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W. II</b>		17. SOCIAL SECURITY NO. <b>9</b>	
15. MOTHER'S MAIDEN NAME <b>Anna?</b>		18. INFORMANT <b>Ann Anna Yaska - 725 McHenry St.</b>	
19. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic and Hypertensive Cardio-vascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>443X II</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		DATE SIGNED <b>4/29/68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/1/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Balti. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>	
25C. FUNERAL DIRECTOR <b>John J. Cowan</b>		ADDRESS <b>San, Inc. 901 Hollins St. Balt. Md.</b>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 4530

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDDA M. PENNELL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> April 28, 1968 10:00 AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 411 Edsdale XXXXX Road		3. DATE PRONOUNCED DEAD Month Day Year April 28, 1968 10:00 AM	
6. SEX female		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
7. RACE white		C. CITY OR TOWN Baltimore	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH May 1, 1887		10. AGE (In years lost birthday) 80	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. FATHER'S NAME XX Jesse Simpson	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Ida Mae (Unknown)	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 216-20-1018	
18. INFORMANT ADDRESS 21229 Mr. Charles H. Pennell, 411 Edsdale Road			
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. DATE SIGNED 4/29/68 EXAMINER'S NAME (Type) Werner U. Spitz, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-2-1968	
24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Jarboe	
25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4531

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

68- 4531

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

COULTER, CLARENCE ROTH

2. DATE AND HOUR OF DEATH

04 27 68- 12:35

A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST. AGNES HOSP  
WILKENS & CATON AVES  
BALTO MD 21229

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

8. COUNTY

MD

HARFORD

62-00

C. CITY OR TOWN

EDGEWOOD

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

2106 RAILROAD AVE

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

10 09 06

9. AGE (In years last birthday)

61

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

TRUCK DRIVER

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Govt.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

MORRIS COULTER (DEC'D)

14. MOTHER'S MAIDEN NAME

EMMA V. Bunce (DEC'D)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

213 18 0138

17. INFORMANT

ADDRESS

ST AGNES HOSP CATON & WILKENS AVE

18.

519.1

I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Ac. pulmonary edema  
(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

527.2

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from APRIL 24 19 68 to APRIL 27 19 68, that (I) (we) last saw the deceased alive on APRIL 27 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

S. KORTZULY M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4/28/68

23C. PHYSICIAN'S NAME (Type)

S. KORTZULY M.D.

23D. ADDRESS

WILKENS & CATON AVE  
ST. AGNES HOSPITAL-BALTO., MD. 21229

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Apr. 30, 1968

24C. NAME OF CEMETERY or CREMATORY

Cokesbury Memorial Cemetery

24D. LOCATION

Abingdon

(City, town, or county)

(State)

Harford

MD

25A. DATE REC'D BY HEALTH DEPT.

APR 30 1968

25B. NAME OF REGISTRAR

Robert E. Fawcett

25C. FUNERAL DIRECTOR

Howard K. McComas & Son, Abingdon, Md.

ADDRESS

COUNTER, CLARENCE ROTH

1211

20020000

21 & 22ND AVE

1 12 12 12

U.S.A.

SHAWLAND

100000 (10000)

ST. AGNES HOSP  
WILKINS & CATON AVE  
BALTO MD 21202

M.V.

TRUCK DRIVER

THOMAS COUNTER (10000)

NO 10000 ST AGNES HOSP CATON & WILKINS AVE

APRIL 27

APRIL 27

APRIL 27

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 4532 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 4532

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SUE SACHS</b>		2. DATE AND HOUR OF DEATH <b>4/29/68</b> <b>4 20/A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>53-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSP</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>11 COBBELSTONE CT.</b>		F. DATE OF BIRTH <b>4/15/196</b>		G. AGE (In years lost birthday) <b>72</b>	
H. SEX <b>F</b> I. RACE <b>W</b>		J. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> KIDNOWN <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		L. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
M. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES LADY</b>		N. KIND OF BUSINESS OR INDUSTRY		O. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
P. FATHER'S NAME <b>ISRAEL GOLDSTEIN</b>		Q. MOTHER'S MAIDEN NAME <b>ESTER SWORZYN</b>		R. SOCIAL SECURITY NO. <b>091-10-5106</b>	
S. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dotes of service) <b>NO</b>		T. INFORMANT <b>MRE GERTRUDE BLUMSON</b>		U. ADDRESS <b>SAME</b>	
V. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>205.0 I</b>		W. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ACUTE MYELOCYTIC LEUKEMIA</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
X. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloing the UNDERLYING CONDITION lost. <b>204.3 II</b>		Y. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
Z. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>4/19/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Laryngeal Stridor</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>4/18</b> 19 <b>68</b> to <b>4/29</b> 19 <b>68</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>4/29</b> 19 <b>68</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>W. H. Oehlert</b>				23B. DATE SIGNED <b>4/29/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM H. OEHLERT MD.</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/1/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mushon Israel Baltes</b>	
24D. LOCATION (City, town, or county) (State) <b>md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>Sydney S. Lewis &amp; Son, INC</b>		25D. ADDRESS <b>Gaithersburg</b>			

THE LIBRARY OF THE

UNIVERSITY OF MICHIGAN

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4533

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4533

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHRISTIAN FISKE</b>		2. DATE AND HOUR OF DEATH <b>APRIL 28 1968</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>4600 ELSRODE AVE</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>27-02</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>4600 ELSRODE AVE</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 30 1890</b>	9. AGE (In years lost birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MACHINERY</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CHARLES F FISKE</b>			
14. MOTHER'S MAIDEN NAME <b>EMMA CAROLINE SOHAT</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>373-01-4872</b>		17. INFORMANT ADDRESS <b>ALMA L FISKE 4600 ELSRODE AVE</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>185X I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b>		<b>Days</b>	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Infection</b>		<b>Wks</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(C) <b>Ca prostate &amp; benign metastases</b>		<b>Years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>177X II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-20</b> 19 <b>67</b> to <b>4-25</b> 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>4-23</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>RK Gundry MD</b>				23B. DATE SIGNED <b>4-29-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>RK GUNDY</b>				23D. ADDRESS <b>2 W University Pkwy 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>MAY 1 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>DULANEY VALLEY MEMORIAL</b>	
24D. LOCATION (City, town, or county) (State) <b>TIMONIUM MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>DIPPEL BROS INC 7110 BELAIR ROAD</b>			





FUNERAL DIRECTOR: IMPORTANT

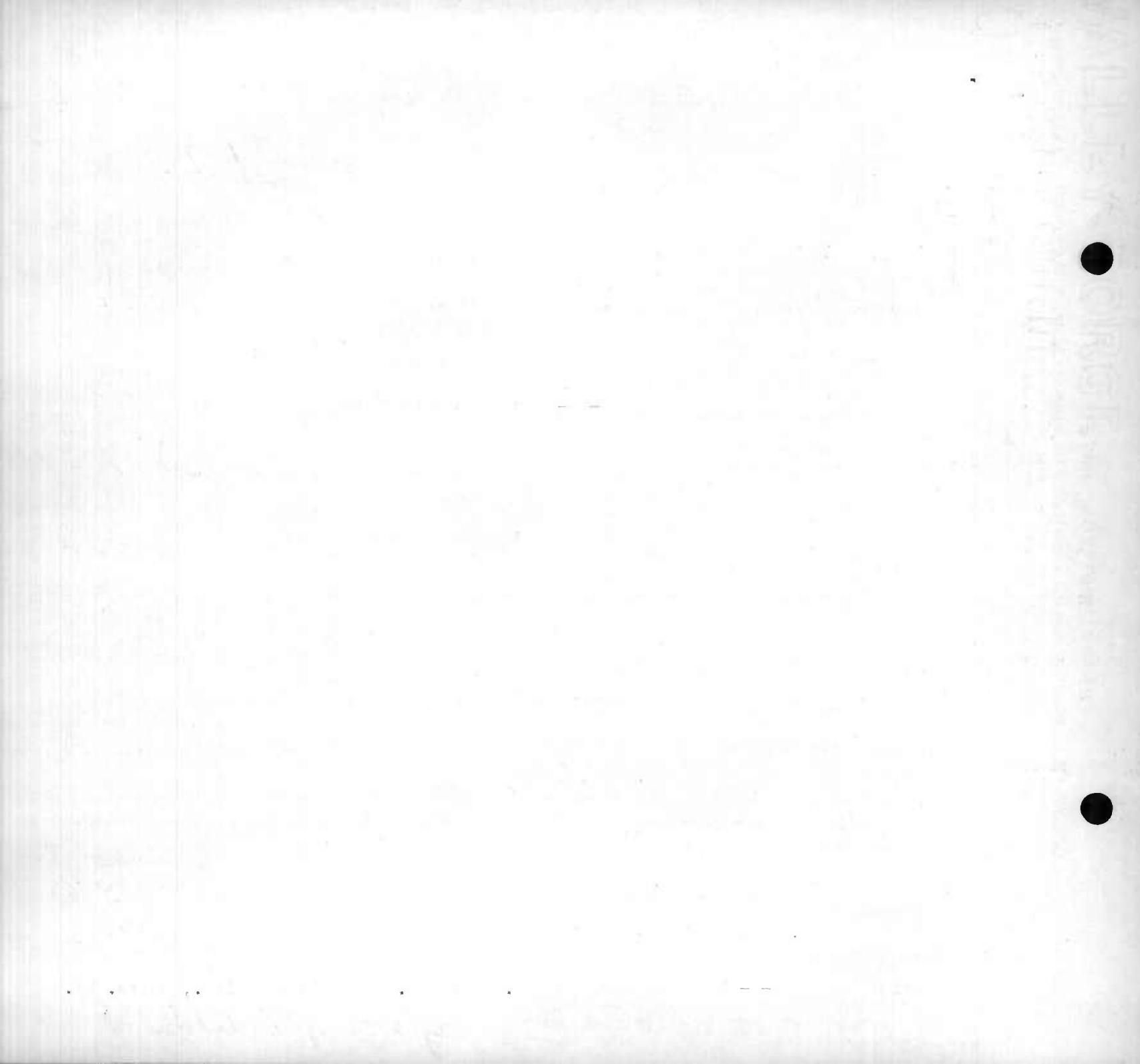
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4534

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-4534

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>HELEN W. ROGERS</u>		2. DATE AND HOUR OF DEATH <u>4-29-68</u>   <u>3:10 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSURANCE LIMITS? <u>19-042</u>	
				E. STREET AND NUMBER <u>329 S. MONROE ST.</u>	
5. SEX <u>Female</u>	6. RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-20-24</u>	9. AGE (In years last birthday) <u>43</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ice Cream Packer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Ice Cream</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George N. Brown</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN Frances</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-12-9863</u>		17. INFORMANT ADDRESS <u>Caroline Ruhl - daughter 329 S. Monroe St.</u>	
18. <u>431.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Intracerebral hemorrhage</u> <u>hours</u> DUE TO, OR AS A CONSEQUENCE OF: <u>POSS.</u> (B) <u>Hypertension</u> <u>years</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>331X II</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>YES</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>4-28</u> 19 <u>68</u> to <u>4-29</u> 19 <u>68</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>4-29</u> 19 <u>68</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Angel S. Gonzalez</u>				23B. DATE SIGNED <u>4/29/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>ANGEL S. GONZALEZ MD.</u>		23D. ADDRESS <u>Bon Secours Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-2-68</u>		24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Mem. Park Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Washington Blvd., Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 30 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, MA</u>	
25C. FUNERAL DIRECTOR <u>John &amp; Thomas Michael &amp; Son</u>		25D. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 68- 4535 BALTIMORE CITY HEALTH DEPARTMENT 68- 4535 CERTIFICATE OF DEATH

REG. NO. 68- 4535

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Cora Dennis		4/12/68 2:40 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland	
13 SOUTH BALTIMORE GENERAL HOSPITAL				C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				921 Bevan Street	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	Colored		5/21/92	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Unknown	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Helen White 11500 Henrich St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4-36.9 + 250.9		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: pneumonia		1-2 wks	
ANTECEDENT CAUSES		(B) Dehydration DUE TO, OR AS A CONSEQUENCE OF:		?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Cerebrovascular accident		?	
331X II		Diabetes mellitus			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
8				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/8/68 19 to 4/12/68 19, that (we) lost the deceased on 4/12/68 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Thomas H. Emory M.D.				4/17/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
THOMAS H. EMORY M.D.				S.B.G.H. - 1213 Light Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/12/68		Mt Calvary	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 30 1968		Robert E. Farkner		108 108	
				ADDRESS	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4536

BIRTH NO. *Ohio*

1. NAME OF DECEASED (Type or Print) <b>PATTY SUE JOHNSON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 25, 1968</b> Hour <b>1:45 A. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 25, 1968</b> Hour <b>1:45 A. M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>ANNE ARUNDEL</b>		C. CITY OR TOWN <b>Pasadena (Green HAVEN)</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Feb. 16, 1967</b>		10. AGE (In years lost birth day) <b>1</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		14B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
15. MOTHER'S MAIDEN NAME <b>Lorene Pater</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no none</b>	
17. SOCIAL SECURITY NO. <b>None</b>		18. INFORMANT <b>Mr. John M. Johnson (father)</b> ADDRESS <b>Same as #5</b>	
19. <b>E968 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Blunt injuries of abdomen</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>E983 X</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>210 St. &amp; Catherine Avenue</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>4-24-68</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Child was beaten</b>		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>April 25, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/27/1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Edna E. Fadden</b>	
25C. FUNERAL DIRECTOR <b>Singleton Funeral Home</b>		ADDRESS <b>Glen Burnie, Md.</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
BIRTH NO. <b>68-07236</b>		68- 4537		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
DORA MAE HARRIS			4-26-68 9.33 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
33 THE JOHNS HOPKINS HOSPITAL			MARYLAND BALTIMORE CITY		
			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER		
			1735 GUILFORD AVE.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
FEMALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-23-68	----	3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
			MARYLAND		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
DAVID HARRIS			EULA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			2 1/2 days		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Transposition of the Great Vessels		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
4/25/68			Diagnostic cardiac catheterization & Rashkind procedure		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
YES			No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		
(Month) (Day) (Year) (Hour)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4/25 19 68 to 4/26 19 68, that (I) (we) last saw the deceased alive on 4/26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Michael A. Simmons, M.D.			4/26/68		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
MICHAEL A. SIMMONS			THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
CREMATION		4-29-68		THE JOHNS HOPKINS HOSPITAL BALTO., MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 30 1968		Robert E. Taylor		HOSPITAL DISPOSAL	

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P-624

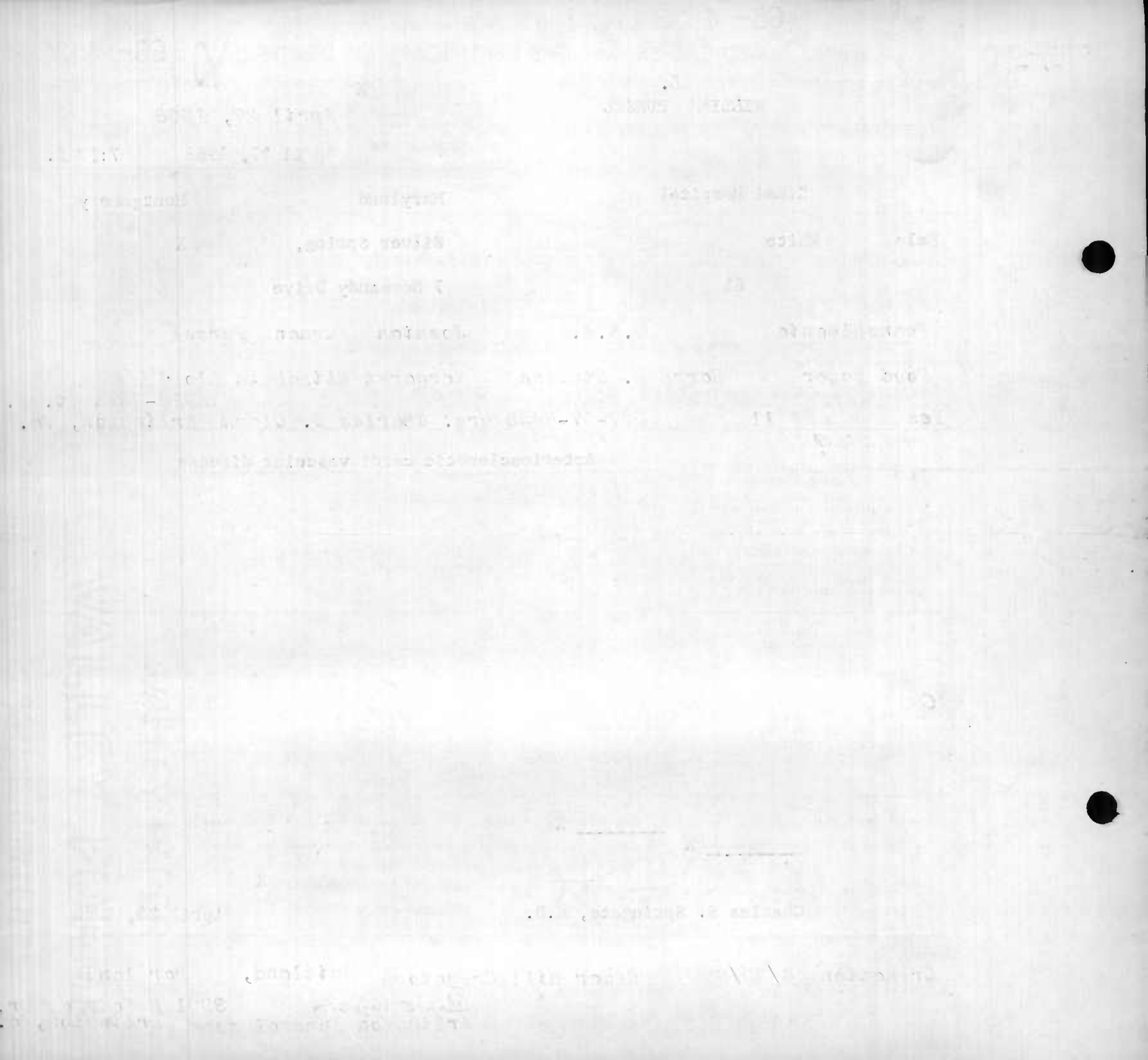
68-4538 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-4538

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM PURSEL</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 27, 1968</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 27, 1968 7:50 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Silver Spring,</b>	
9. DATE OF BIRTH <b>61</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) <b>61</b>		E. STREET AND NUMBER <b>7 Normandy Drive</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joshiah Furman Pursel</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Food Buyer</b>	
15. MOTHER'S MAIDEN NAME <b>Margaret Elizabeth Lloyd</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 11</b>	
17. SOCIAL SECURITY NO. <b>577-07-8458</b>		18. INFORMANT <b>Mrs. Charles T. Clark</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. DATE OF OPERATION <b>0</b>		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Arteriosclerotic cardiovascular disease</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Arteriosclerotic cardiovascular disease</b>		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <b>April 27, 1968 7:50 A.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Arteriosclerotic cardiovascular disease</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		DATE SIGNED <b>April 28, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>4/30/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Crematory</b>		24D. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Bur. E. Taylor</b>		25D. ADDRESS <b>9901 N Fairfax Dr. Arlington Funeral Home Arlington, Va.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4539
M-200 68- 4539		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>McCoy, Lee NMI</b>		2. DATE AND HOUR OF DEATH <b>April 29, 1968 9:35 A.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>108 S. Calverton Road</b>				
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/30/24</b>	9. AGE (In years last birthday) <b>43</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cardboard Stripper</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Addie Will McCoy</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Anthony</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 7/9/43 - 2/14/44</b>		16. SOCIAL SECURITY NO. <b>217-18-2969</b>		17. INFORMANT <b>VA Hospital Records</b> <b>3900 Loch Raven Blvd., Balto., Md 21218</b>
18. <b>15-19 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Stomach with metastasis to liver</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>1 year</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. DATE OF OPERATION <b>6/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Stomach ulcer or malignancy</b>		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>March 4th</b> 19 <b>68</b> to <b>April 29th</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>April 29th</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>George W. Gaffney</b>		23B. DATE SIGNED <b>April 29, 1968</b>		
23C. PHYSICIAN'S NAME (Type) <b>George W. Gaffney, M.D.</b>		23D. ADDRESS <b>3900 Loch Raven Blvd., Balto., Md 21218</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5-2-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Charles R. Law</b> ADDRESS <b>802 Madison Ave.</b>

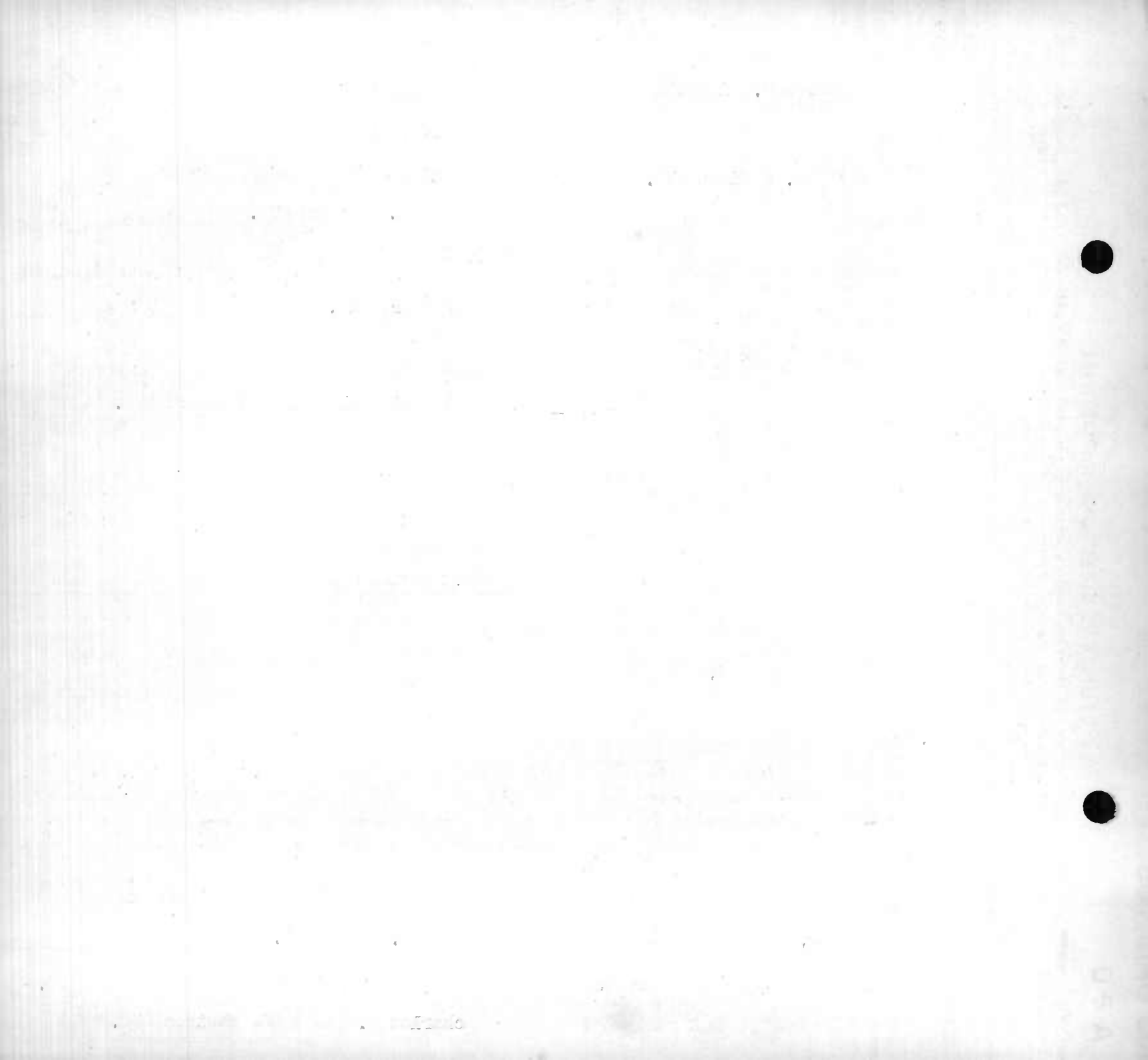
George H. Brown

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-524		68- 4540		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 4540	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>George S. Ringgold</b>			
2. DATE AND HOUR OF DEATH <b>April 26, 68 2:45 P. M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>				5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2503 N. Madison AVE.</b>			
6. DATE OF BIRTH <b>3/ 1/ 1896</b>				7. AGE (In years lost birthday) <b>72</b>		8. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. SEX <b>M</b>				10. RACE <b>C</b>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				13. KIND OF BUSINESS OR INDUSTRY <b>C&amp;P Telephone</b>		14. BIRTHPLACE (State or foreign country) <b>Baltimore MD.</b>	
15. FATHER'S NAME <b>George Ringgold</b>				16. MOTHER'S MAIDEN NAME <b>U S A</b>			
17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				18. SOCIAL SECURITY NO. <b>212 05 0529</b>		19. INFORMANT <b>Otho Ringgold 5227 Denmore AVE.</b>	
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>myocardial failure</b>				21. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>antiorosclerotic cardio vas-</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>enlarged disease -</b> (C) DUE TO, OR AS A CONSEQUENCE OF: <b>none</b>			
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>422.1 II</b>				23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
24. DATE OF OPERATION <b>0</b>		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) <b>NO</b>		27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		31. HOW DID INJURY OCCUR?	
32. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		33. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		34. DATE SIGNED <b>4/26/68</b>		35. SIGNATURE <b>Dr. Herman Seidel</b>	
36. I certify that (I) (this hospital) attended the deceased from <b>10/22/65</b> to <b>April 26, 1968</b>		37. that (I) (we) last saw the deceased alive on <b>April 26, 1968</b>		38. and that in (my) (our) opinion death occurred on the date <b>April 26, 1968</b>		39. and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
40. PHYSICIAN'S NAME (Type) <b>Dr. Herman Seidel</b>		41. ADDRESS <b>2404 N. Eutaw Place</b>		42. DATE <b>4/30/68</b>		43. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem Park</b>	
44. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		45. LOCATION (City, town, or county) <b>Baltimore</b>		46. STATE <b>MD.</b>		47. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>	
48. NAME OF REGISTRAR <b>Robert E. Ischey</b>		49. FUNERAL DIRECTOR <b>Charles R. Law</b>		50. ADDRESS <b>802 Madison AVE.</b>		51. DATE <b>APR 30 1968</b>	





31-13-38 LB

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4541	
1. NAME OF DECEASED (Type or Print) <b>GLORIA CARTER</b>		2. DATE AND HOUR OF DEATH <b>4/25/68 3:30 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND #21224</b>		A. STATE <b>MARYLAND</b>		B. COUNTY	
C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
E. STREET AND NUMBER <b>5505 WILVAN AVENUE 21207</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-5-37</b>	9. AGE (In years last birthday) <b>30</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technician</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>JACOB FINNEY</b>		14. MOTHER'S MAIDEN NAME <b>CHUCKLEY, ADELA CROPPER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-34-9284</b>		17. INFORMANT ADDRESS <b>RECORDS: BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE., BALTO., MD. 21224</b>	
18. <b>201X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY ARREST DUE TO PNEUMONIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>X 2 DAYS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>201X II</b>		(B) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF: <b>X 1 YR.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>—</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>4/22 1968</b> to <b>4/25 1968</b> , that (I) (we) last saw the deceased alive on <b>4/25 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. J. Green</b>		23B. DATE SIGNED <b>4/25/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>SEYMOUR MISHKIN M.D.</b>		23D. ADDRESS <b>4940 EASTERN AVE., BALTO., MD. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-29-68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles R. Law - 802 Madison Ave.</b>	

12-24-1923

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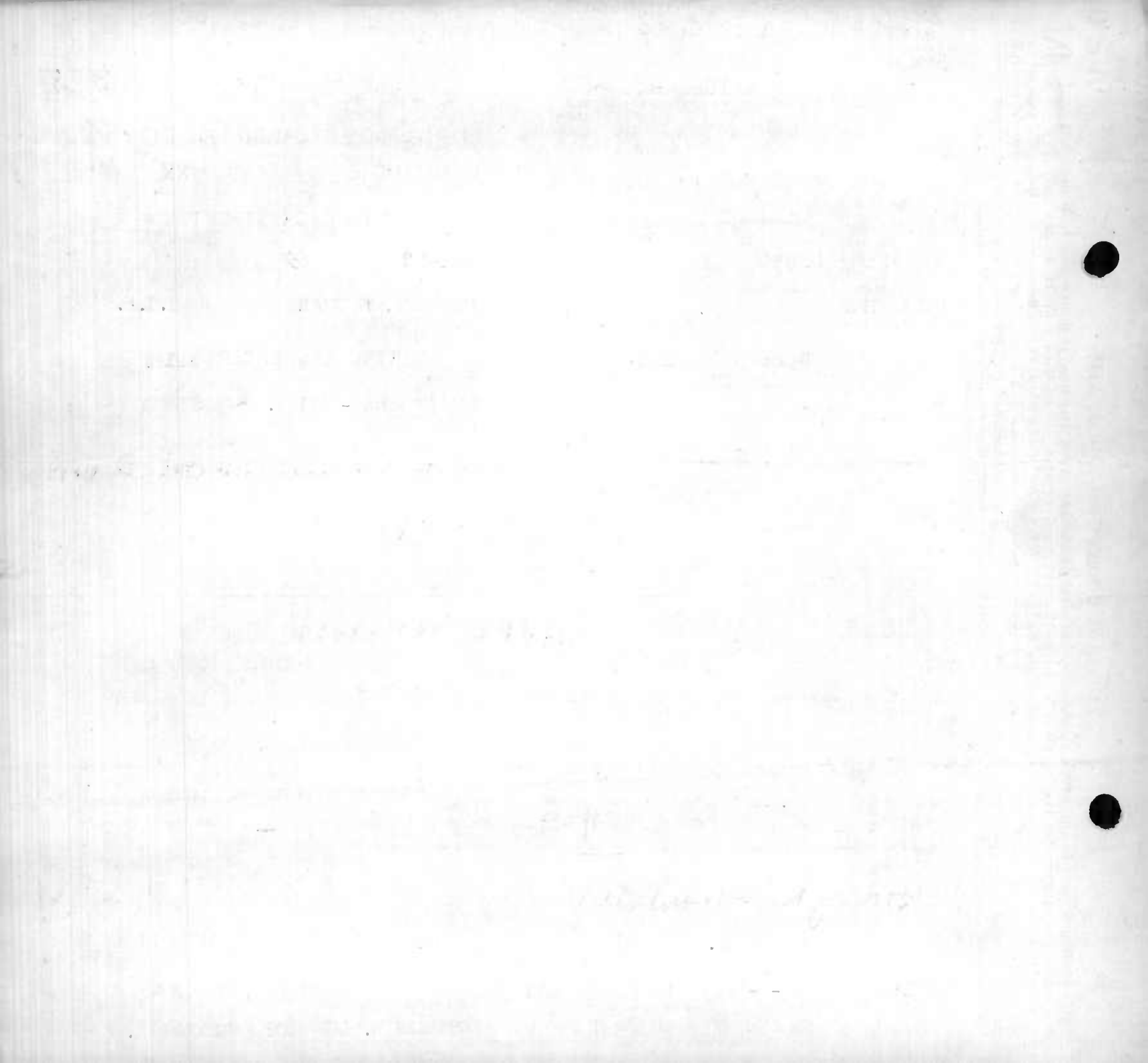
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68-4542</b>	
A-400 68-4542		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		4/27 3:35 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
ALICE KHAN ALLY		A. STATE MARYLAND B. COUNTY BALTIMORE CITY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
33 THE JOHNS HOPKINS HOSPITAL		BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		E. STREET AND NUMBER	
FEMALE		651 NORTH PACA STREET	
6. RACE		8. DATE OF BIRTH	
NEGRO		5-2-02	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. AGE (In years last birthday)	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		BALTIMORE, MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
ROBERT MOSELEY		GERTRUDE SPENCER Akles	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO			
17. INFORMANT		ADDRESS	
SHARIF KHAN - 651 N. PACA STREET			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		2 DAYS	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		ACUTE MYOCARDIAL INFARCTION	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCVD	
		(C) HYPERTENSION	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)	
4-20-68		YES	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/24/68 to 4/27/68, that (I) (we) saw the deceased alive on 4/27/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
HARRY K. GENANT MD		4/27/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
HARRY K. GENANT		THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
BURIAL		5-1-68	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BALTIMORE NATIONAL		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
APR 30 1968		Robert E. Fairburn	
25C. FUNERAL DIRECTOR		ADDRESS	
CHARLES R. LAW		802 MADISON AVE.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="border: 1px solid black; padding: 2px;">X</span> 68-4543
D-200 68-4543		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		
		DISE, JOHANNA MARGARET		
2. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229		APRIL 28, 1968   8:20 P. M.		
		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 21207		
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 08-22-02		9. AGE (In years last birthday) 65		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME PETER MC MANUS		14. MOTHER'S MAIDEN NAME MAMIE CLANCY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Betty Clark, 1227 Dorchester Ave., Balto. ST. AGNES RECORDS, WILKENS & CATON AVES
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  410.941 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus -		CAUSE OF DEATH Acute myocardial infarct. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  A-S-E-U-D - (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION 4/25/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Surg. removal of foot		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from APRIL 8 1968 to APRIL 28 1968, that (X) (we) last saw the deceased alive on APRIL 28 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.				
23A. SIGNATURE Alejandro Meia, M.D. ALEJANDRO MEIA, M.D.				23B. DATE SIGNED 4-28-68
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS WILKENS & CATON AVES, BALTO 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-68		24C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery
24D. LOCATION Balto.		24E. LOCATION (City, town, or county) (State) Md.		
25A. DATE REC'D BY HEALTH DEPT. APR 30 1968		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Witzke Funeral Directors, Balto., Md. 21229

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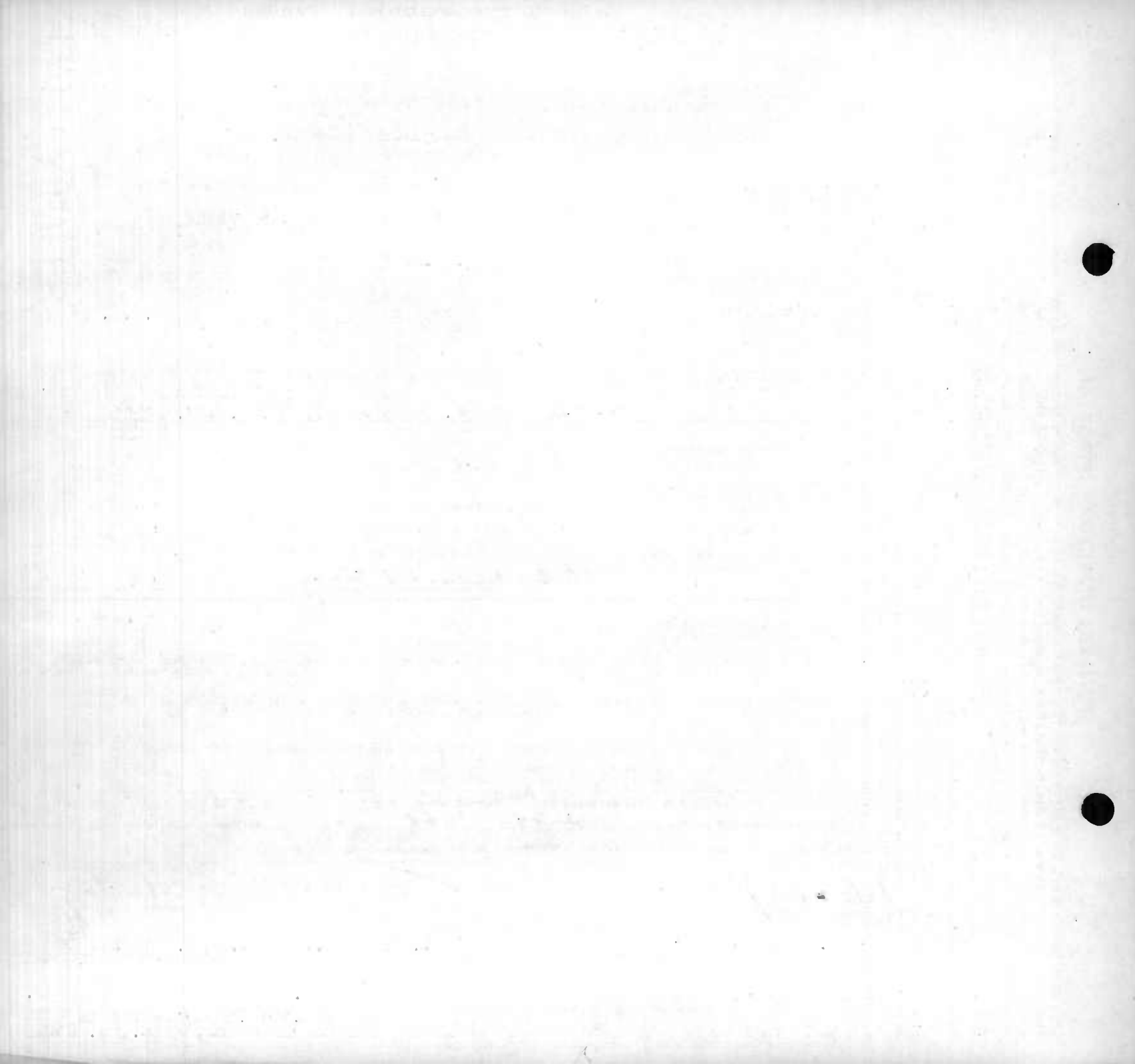
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 4544</b>
BIRTH NO. <b>P-123</b>		<b>68- 4544 CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>William Pabst</b>		2. DATE AND HOUR OF DEATH <b>4-28-68 11:50</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>5221 Linden Heights Avenue</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>5221 Linden Heights Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-19-1888</b>	9. AGE (In years last birthday) <b>79</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Electrician</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>214-01-2374 A</b>		17. INFORMANT <b>Mrs. Daisy Pabst, Balto., Md. 21215</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>1-Cerebral Vascular Accident - 1 hr. duration</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>2-Cerebral &amp; Coronary insufficiency</b> (C) <b>3-Dementia's + 67 Blazig</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs (Jan '67)</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>331X II</b>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 12, 1968</b> to <b>4-28-68</b> , that (I) (we) last saw the deceased alive on <b>3-29-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Dr. Bernard Cohen</b>		23B. DATE SIGNED <b>4/29/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Bernard Cohen</b>
23D. ADDRESS <b>3501 St. Paul St., Balto., Md. 21218</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>5-1-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbairn</b>		25C. FUNERAL DIRECTOR <b>Witzke Funeral Directors, Balto., Md. 21229</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4545	
68- 4545					
BIRTH NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>BODDIE, MARY</b>			2. DATE AND HOUR OF DEATH <b>4-28-68 11:45</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-10</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>4015 Main Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>N. N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-26-98</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>	
13. FATHER'S NAME <b>James Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Bettie Bunn</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>James Boddie 1330 N. Potomac St.</b>	
18. <b>15-7-9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>UPPER GI BLEEDING</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARCINOMA OF PANCREAS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ... APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b> <b>8 MONTHS</b>		19. <b>15-7-X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-28 1968</b> to <b>4-28 1968</b> , that (I) (we) last saw the deceased alive on <b>4-28 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Major W. Bradshaw M.D.</b>				23B. DATE SIGNED <b>4-28-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MAJOR W. BRADSHAW M.D.</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 3/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Carver Memorial</b>	
24D. LOCATION (City, town, or county) (State) <b>Laurel Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Frank E. Eubank 1129 N. Carroll St</b>	

Gettin' better  
4

40-25-92 LB

68- 4546

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 68- 4546

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LEE, BERTHA L.

2. DATE AND HOUR OF DEATH

4/28/68 4-28-68 5:15 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 BALTIMORE CITY HOSPITALS  
4940 EASTERN AVE., BALTO., MD. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

8. COUNTY

MARYLAND

Balto C 53-00

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

329 BACK RIVER NECK RD. 21221

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

9-4-91

9. AGE (In years last birthday)

76

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM DeMINDS

14. MOTHER'S MAIDEN NAME

CLEMENTINE BROWN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

217-09-5891

17. INFORMANT ADDRESS

RECORDS: BALTIMORE CITY HOSPITALS  
4940 EASTERN AVE., BALTO., MD. 21224

18. 250.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

MYOCARDIAL INFARCTION IMMEDIATE

(B) DRY GANGRENE BOTH LOWER EXTREMITIES FEB 1968  
DUE TO, OR AS A CONSEQUENCE OF: + INFECTIONS

(C) DIABETES MELLITUS - ARTERIOSCLEROSIS ?

260X II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

ARTERIAL HYPERTENSION - ASCVD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10 YEARS

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

3/23-3/30-4/6-4/15-4/23

PROGRESSIVE GANGRENE

NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

NO

21C. WHERE DID INJURY OCCUR?

NO

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

NO

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

NO

22. I certify that (I) (this hospital) attended the deceased from MARCH 20 19 68 to APRIL 28 19 68, that (I) (we) last saw the deceased alive on APRIL 28 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

4/28/68

23C. PHYSICIAN'S NAME (Type)

LOUIS A. AYALA M.D.

23D. ADDRESS

4940 EASTERN AVE., BALTO., MD. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 30 1968

Robert E. Taylor

Zephaniah E. Elikson 129 N. Caroline St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

REG. NO.

68-4547

BIRTH NO.

68-4547

1. NAME OF DECEASED  
(Type or Print)

ETHEL MOORE

2. DATE AND HOUR OF DEATH

4-27-68

2:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

THE JOHNS HOPKINS HOSPITAL  
BALTIMORE, MD 21205

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

20 N. BOND STREET

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

4-3-06

9. AGE (In years last birthday)

62

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

M.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

GEORGE BOONE

14. MOTHER'S MAIDEN NAME

SADIE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Edward Boone

1B. 183.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Ovarian

(A) IMMEDIATE CAUSE

Adenocarcinoma widespread.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At ☐ Work Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/25/68 to 4/27 1968, that (I) (we) last saw the deceased alive on 4/27 1968 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Donald B. Spangler M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4/27/68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

DONALD B. SPANGLER M.D.

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

May 4/68

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial

24D. LOCATION (City, town, or county)

Arbutus Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 30 1968

25B. NAME OF REGISTRAR

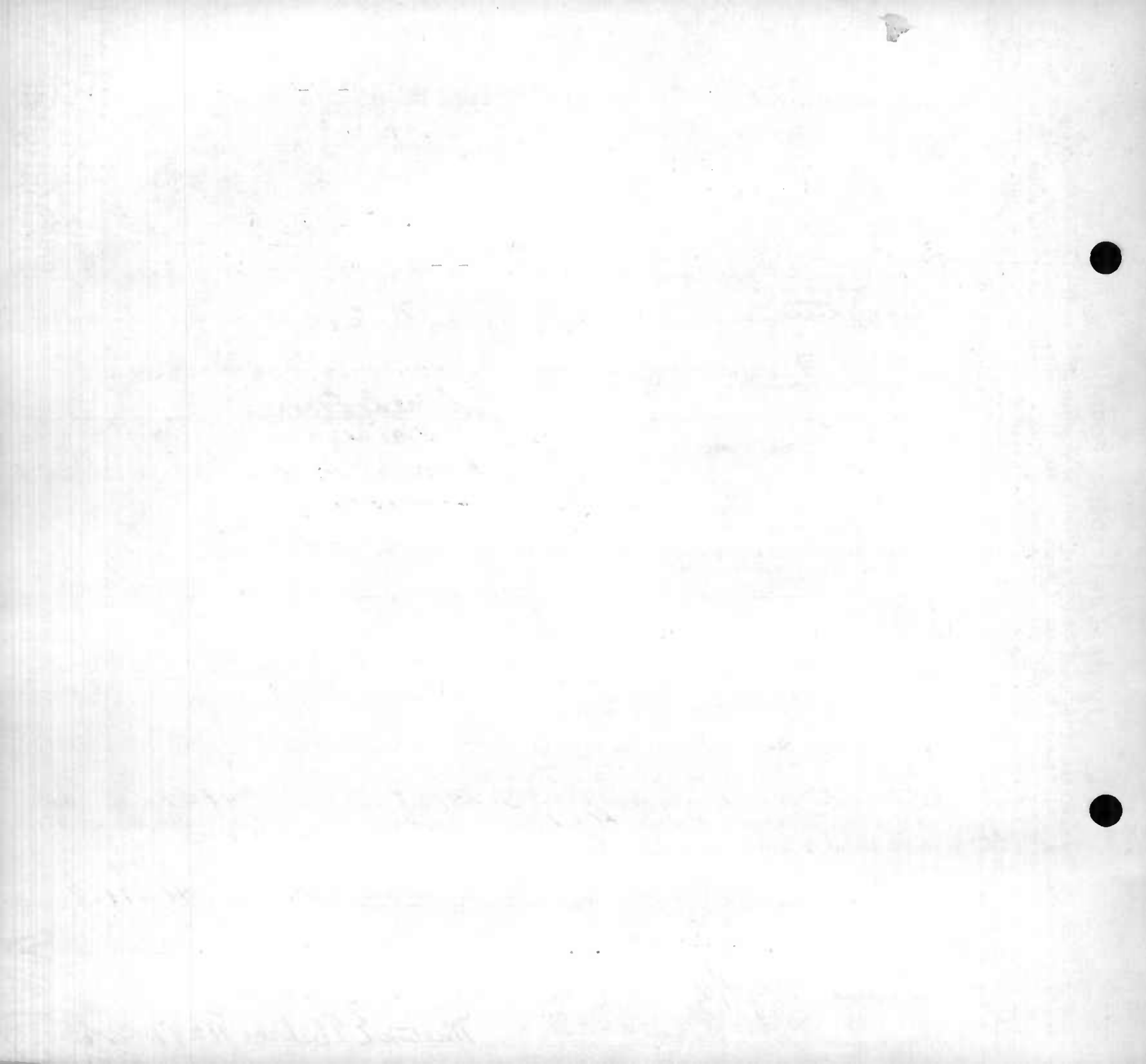
Robert E. Fisher

25C. FUNERAL DIRECTOR

Melton E. Elksan 1129 N. Carroll St

ADDRESS





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 4548</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>68- 4548</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Leila L. Emmett		April 29, 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  5609 Purlington Way		A. STATE		B. COUNTY	
		Maryland			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		5609 Purlington Way			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 31, 1897	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Illinois	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Edward Lewis			Fiok		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-12-8925B		Mr. Paul H. Emmett 5609 Purlington Way 21212	
18. CAUSE OF DEATH					
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
18B. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Vascular Accident</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
18C. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 mos.</i>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>Nov 67</i> to <i>Apr 29 1968</i> , that (I) (we) last saw the deceased alive on <i>April 29 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Wm. G. Helfrich M.D.</i>				<i>4-30-68</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<i>Wm. G. Helfrich M.D.</i>				<i>5006 Roland Ave., Balto., Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/2/68		Riverview Cemetery	
				Portland, Oregon	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<i>APR 30 1968</i>		<i>Robert E. Jankowski</i>		<i>Wm. Cook-Brooks Towson 1050 York Rd. 21204</i>	

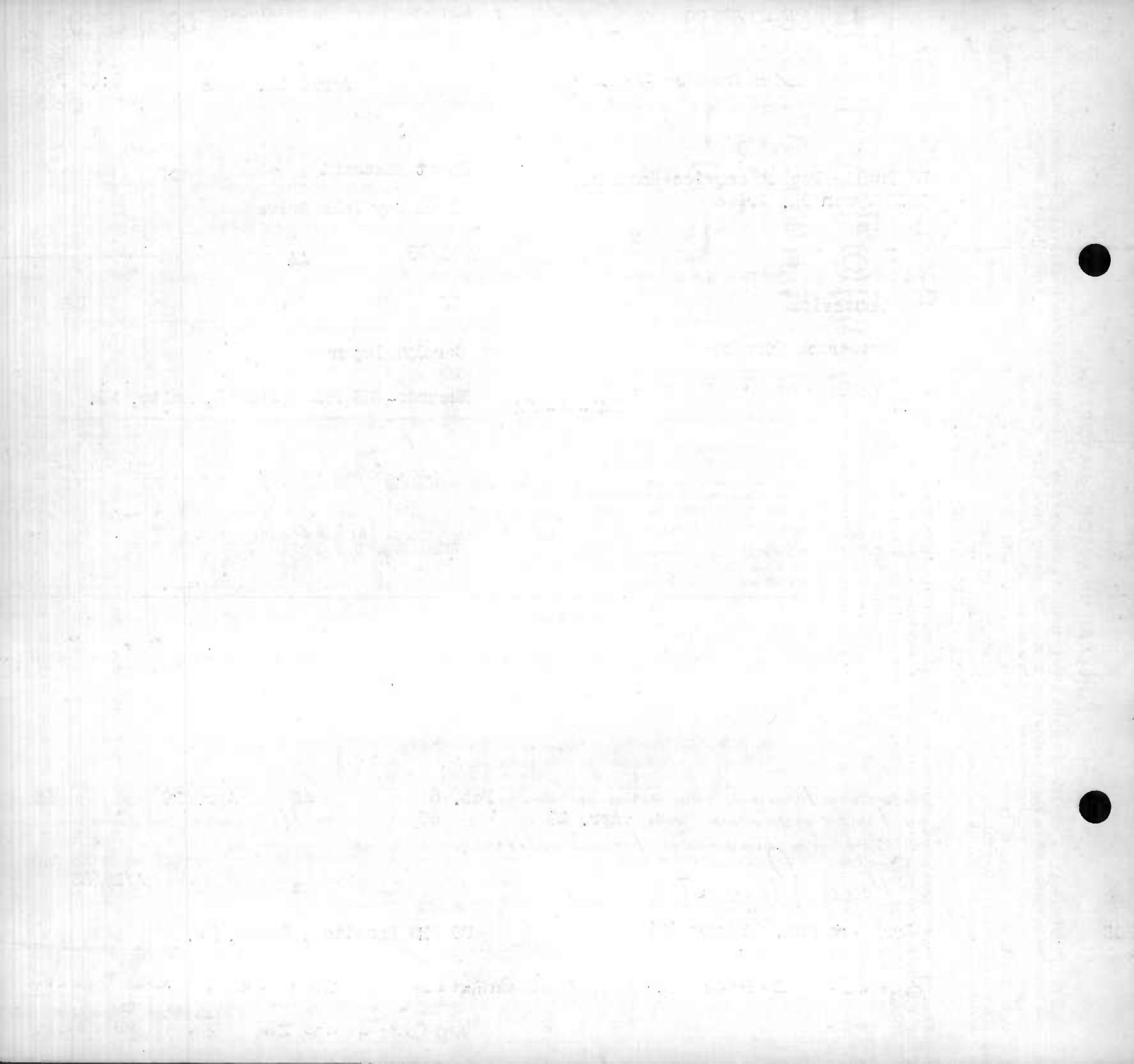
James (or John) ...

James ...

Dr. J. H. ...

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

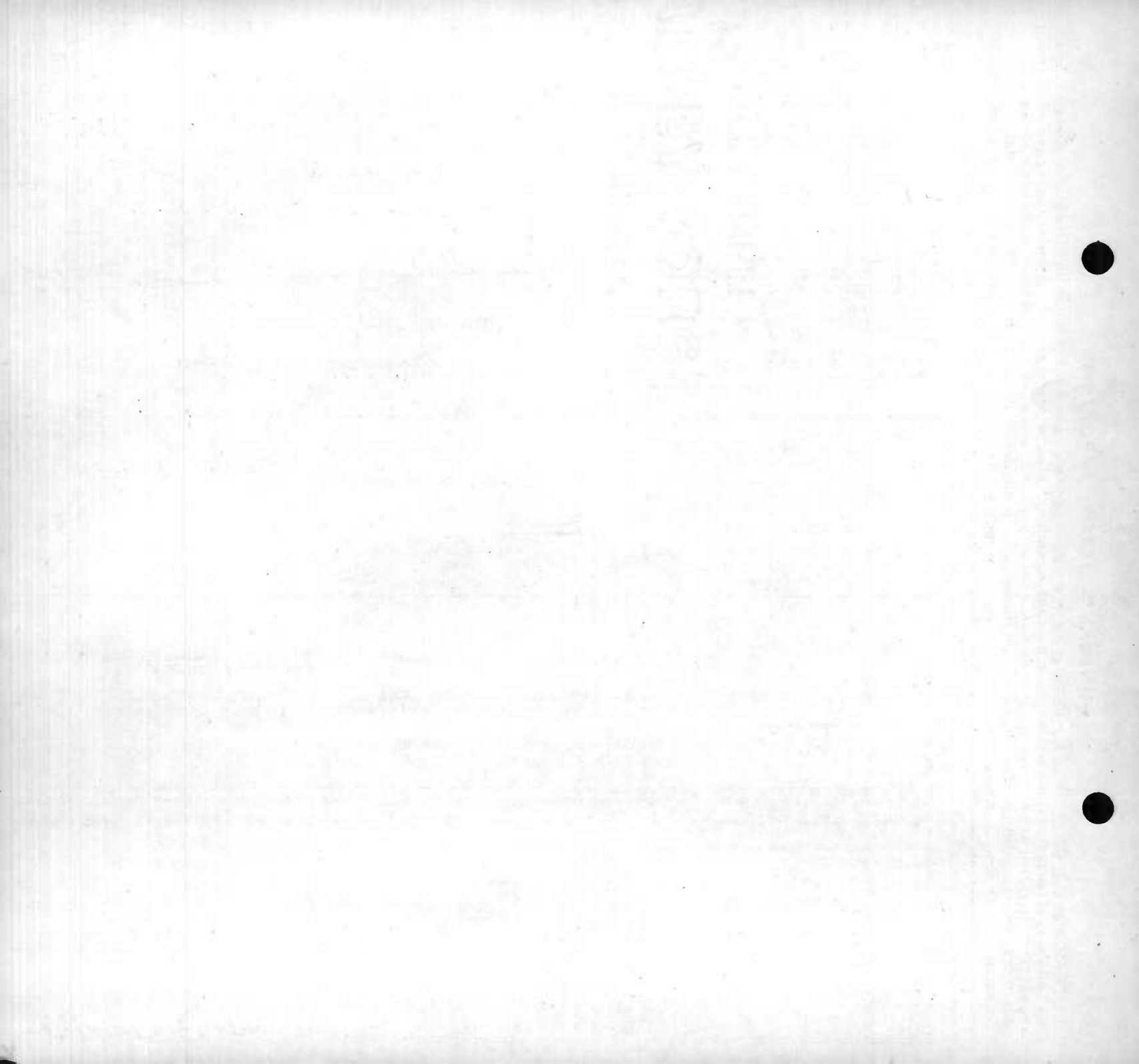
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4549	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Elmira Stauder Lanterman</b>		2. DATE AND HOUR OF DEATH <b>April 29, 1968 3:05 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>NJ</b> B. COUNTY <b>V-27</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b> <b>3100 Wyman Pk. Drive</b>			C. CITY OR TOWN <b>Point Pleasant</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			B. DATE OF BIRTH <b>9/23/23</b>		9. AGE (In years last birthday) <b>44</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>NJ</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Frederick Stauder</b>			14. MOTHER'S MAIDEN NAME <b>Carolyn Meyer</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>142-12-2745</b>		17. INFORMANT <b>Records- US PHS Hospital, Balto, Md.</b>
18. <b>205501</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Septicemia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
(B) <b>Acute myelocytic leukemia</b> DUE TO, OR AS A CONSEQUENCE OF: <b>7 months</b>			(C) _____		
19. DATE OF OPERATION <b>204.3 II</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 6 19 68</b> to <b>Apr. 29 19 68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Apr. 29 19 68</b> and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Cary Present</b>			23B. DATE SIGNED <b>4/29/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Cary Present, SA Surg (R)</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>5-3-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>GREENWOOD Cemetery</b>
24D. LOCATION <b>BRIELLE, NEW JERSEY</b>			25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc.</b>		
25D. ADDRESS <b>1217 St. PAUL St</b>			25E. ADDRESS <b>Balt., Md. 21202</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-250 68-4550				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4550	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ROBERT JACKSON</b>				2. DATE AND HOUR OF DEATH <b>25 APRIL 1968 3:15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>91 MONTABOLLO HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNAPOLIS</b>			
5. SEX <b>MALE</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1/7/08</b>		9. AGE (In years last birthday) <b>60</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Garage work</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Mechanical</b>		11. BIRTHPLACE (State or foreign country) <b>Port Royal, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Unknown</b>			
14. MOTHER'S MAIDEN NAME <b>Maggie Jackson</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>218-14-2379</b>				17. INFORMANT <b>Mrs. Catherine Fisher</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>412.4 I</b> <b>CAUSE OF DEATH</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>433.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>0</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC ARREST</b> <b>MONTHS</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>A.S.C.V.D.</b> <b>YEARS</b> <b>AND Chronic Lung Dis and multiple Scler</b> <b>YEARS</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-7-1967</b> to <b>4-25-1968</b> , that (I) (we) last saw the deceased alive on <b>4-25-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>R. P. ZWENZEL M.D.</b>				23B. DATE SIGNED <b>25 April 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>R. P. ZWENZEL M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>4/29/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Balt. Co. Md.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>Holland Funeral Home-1631 Druid Hill Ave.</b>				25D. ADDRESS <b>Holland Funeral Home-1631 Druid Hill Ave.</b>			





BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 68- 4551									
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) <b>LEROY MILLS</b>					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>4 19 68 6:50 p.m.</b>				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 E. 25th Street D.O.A.</b>					3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 19 1968 6:50 p.m.</b>				
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY <b>Maryland</b>					C. CITY OR TOWN D. INSIDE CITY LIMITS? <b>Balto.</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>34 E. 25th Street</b>			
9. DATE OF BIRTH		10. AGE (In years last birthday) <b>63</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS			
19. <b>412.4 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Atherosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:									
19. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Edward F. Wilson</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): <b>Edward F. Wilson, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>4-30-68</b>		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State) <b>JOHNS HOPKINS MEDICAL SCHOOL</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairley, M.D.</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>		25D. ADDRESS			

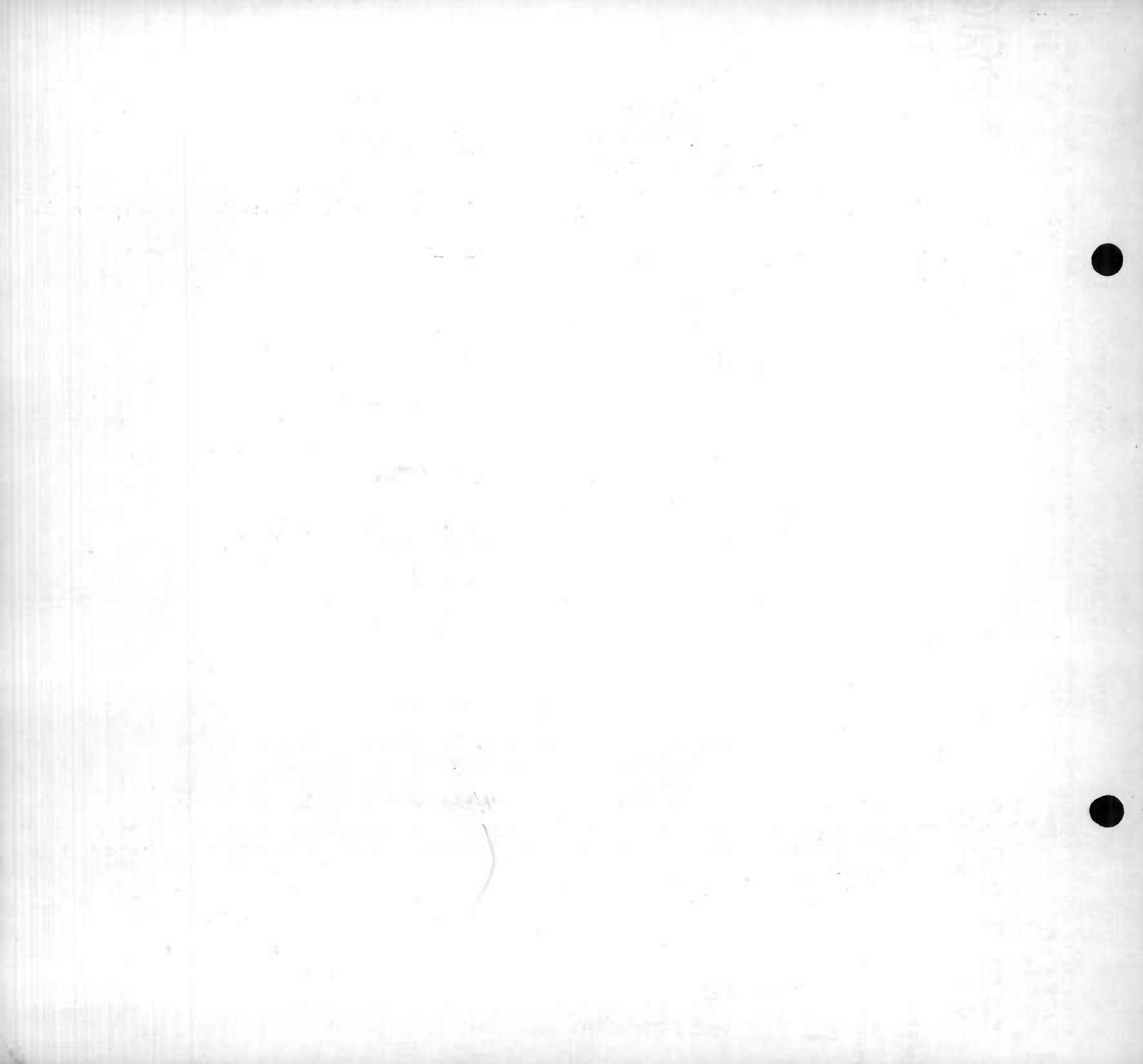
THE UNIVERSITY OF CHICAGO

... 1964

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
5-130		68- 4552		68- 4552	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Joseph Swift		4-8-68		10 30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 21224 4940 Eastern Avenue, Baltimore City Hospitals			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-1868	9. AGE (In years lost birthday) 99	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE POSSIBLE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: UTI or sepsis (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/14/1961 to 4-8-1968, that (I) (we) lost saw the deceased alive on 4-8-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mark Lowmiller M.D.		23B. DATE SIGNED 4-8-68		23C. PHYSICIAN'S NAME (Type) MARK Lowmiller M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-29-68		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. APR 30 1968		25B. NAME OF REGISTRAR Robert E. Fisher M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



B-63568-4553				BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 68-4553			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print)		JUNE CLARA BREIDENSTEIN		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 30, 1968 3:20 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		FULL NAME OF HOSPITAL OR INSTITUTION 833 N. Eutaw Place		3. DATE PRONOUNCED DEAD		Month Day Year March 30, 1968 3:20 P. M.	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 71		E. STREET AND NUMBER		833 N. Eutaw Place	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
19. 182.7 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Uterus (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
174X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <u>Ronald N. Kornblum</u> M.D. EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 3-31-68							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-29-68		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 30 1968		25B. NAME OF REGISTRAR R. E. Johnson		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	

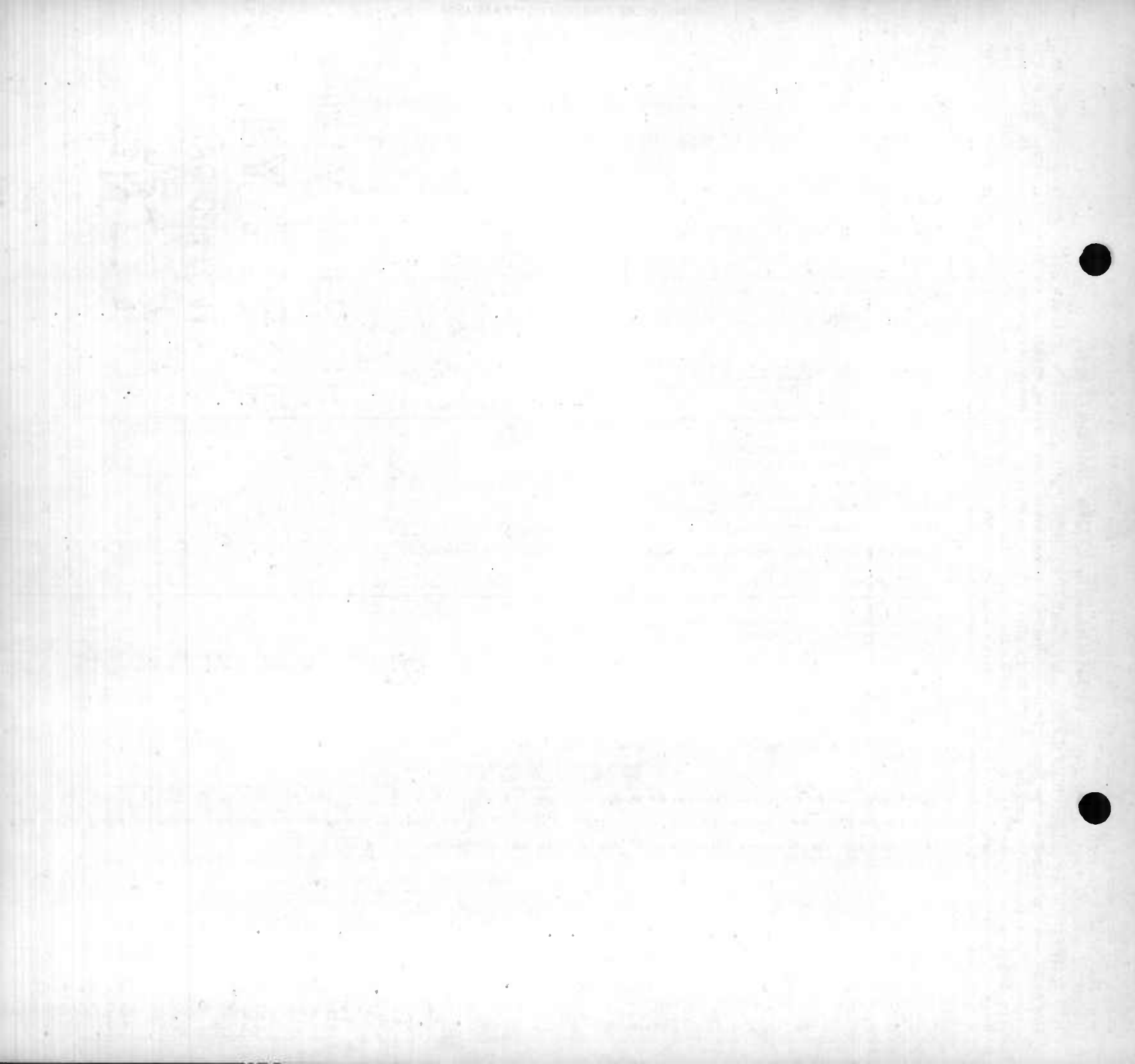
WALTER H. HARRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 4554
<div style="display: flex; justify-content: space-between;"> <span>R-256 68- 4554</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Rasmers, Franz Edward</b>		2. DATE AND HOUR OF DEATH <b>April 29, 1968</b> <b>4:45 P.M.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>City of Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Keswick Home</b>			C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
E. STREET AND NUMBER <b>Keswick 40th St. 13-07</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1888</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Gas &amp; Elec.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Frederick William Rasmers</b>		
14. MOTHER'S MAIDEN NAME <b>Kate Gross</b>			15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		
16. SOCIAL SECURITY NO. <b>215-09-9165</b>		17. INFORMANT ADDRESS <b>Claribel Vickers R.N. Keswick Home</b>			
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <b>Atherosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <b>Diabetes Mellitus</b></p> </div> <div style="width: 5%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>instant</b></p> <p><b>6 yrs</b></p> <p><b>27 yrs</b></p> </div> </div>					
<p><b>260X II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 14</b> 19 <b>68</b> to <b>Apr 29</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Apr 29</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Audrey D. Richardson M.D.</b>				23B. DATE SIGNED <b>29 Apr 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>Audrey D. Richardson M.D.</b>				23D. ADDRESS <b>Keswick Home, 700 W. 40th Street</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/2/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arlington National Cem. Arlington, Virginia</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd Baltimore, 12, Md.</b>			

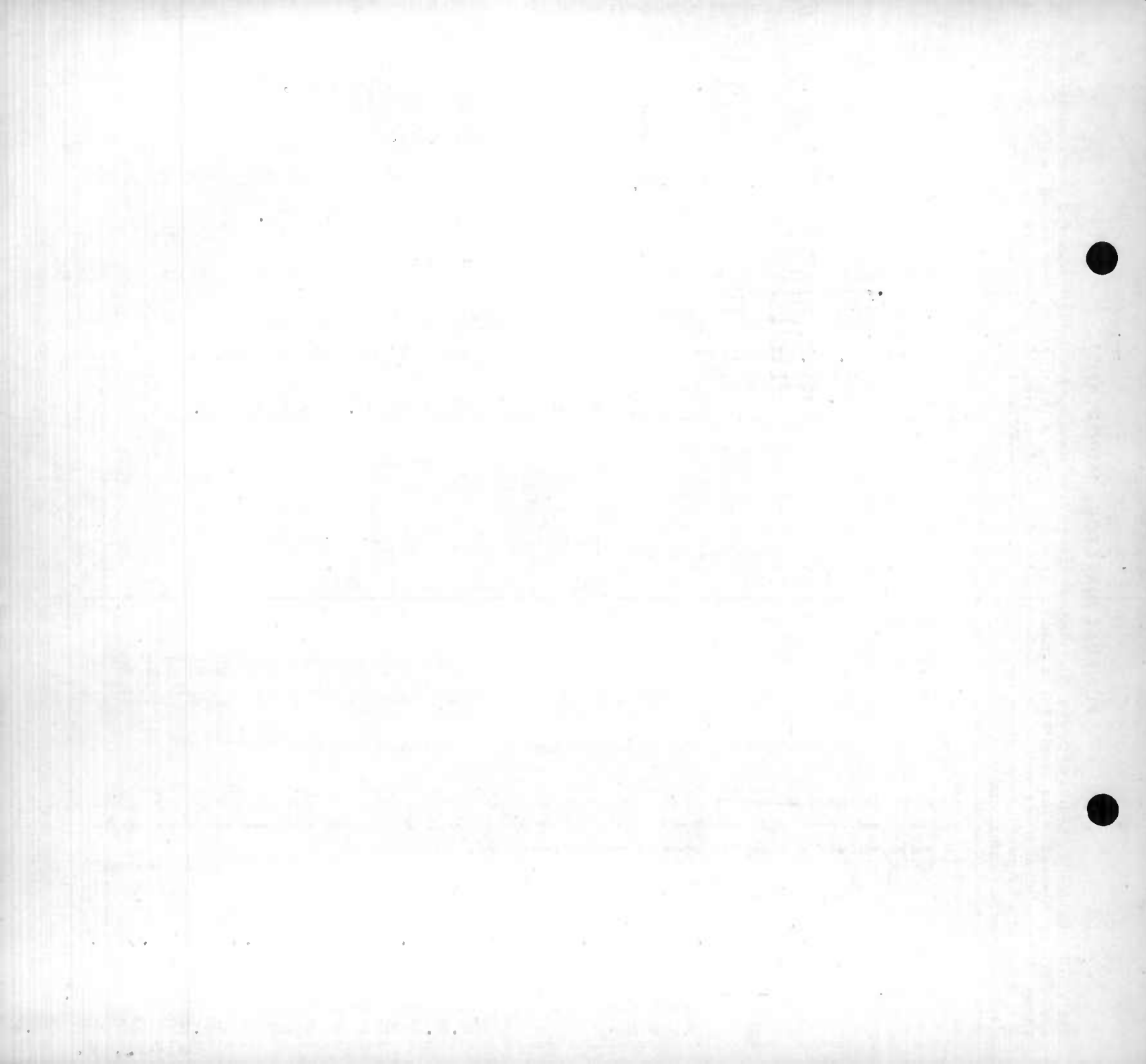




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

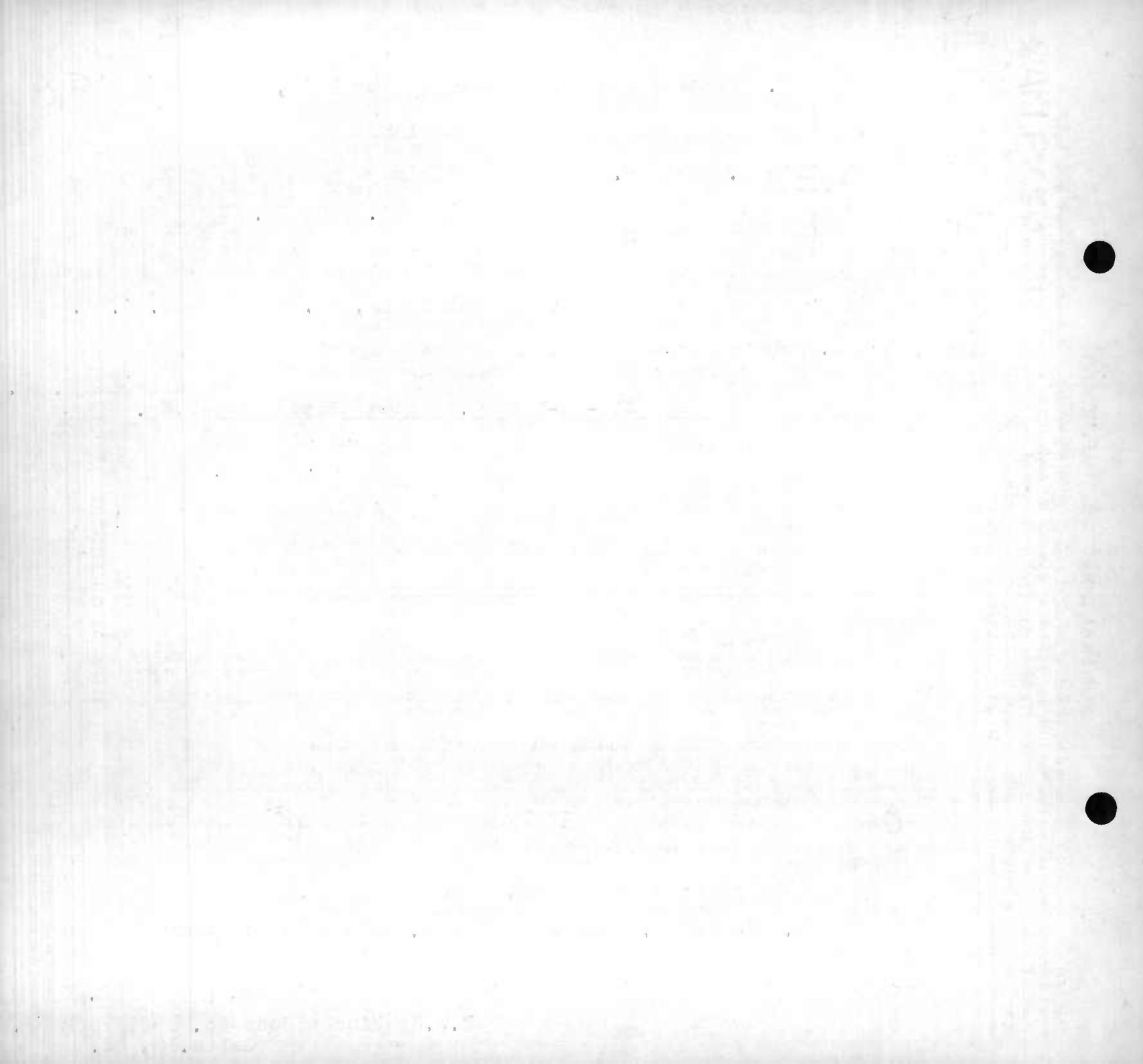
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68-4555</span>
BIRTH NO. <span style="float: right;">68-4555</span>		68-4555 <b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>WILLIAM C. BORDLEY</b>		2. DATE AND HOUR OF DEATH <b>April 26, 1968</b> <span style="float: right;">2:30 p M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>314 Rossiter Ave.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>314 Rossiter Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-1894</b>	9. AGE (In years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Harry F. F. Bordley</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Thompson</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>216-10-9217A</b>		17. INFORMANT <b>William C. Bordley Jr.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>153.9 I</b> <b>URICEMIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Primary Neoplasms of Bone</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>153.9 II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Primary Neoplasms of Bone</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Jan 10 1956</b> to <b>Apr 26 1968</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>April 25 1968</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <b>Charles E. Carr Jr.</b>		23B. DATE SIGNED <b>4/29/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Charles E. Carr Jr. MD</b>
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-29-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md.</b>		



# FUNERAL DIRECTOR: IMPORTANT

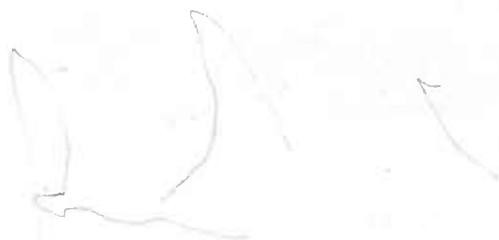
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4556	
5-152 68-4556				<b>CERTIFICATE OF DEATH</b>	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>C. Preston Scheffenacker</b>				April 27, 1968 5 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4102 St. Paul St.</b>				A. STATE <b>Maryland</b>	
				C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <b>4102 St. Paul St.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/26/1903</b>	
9. AGE (In years last birthday) <b>65</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
108. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Charles J. Scheffenacker</b>				14. MOTHER'S MAIDEN NAME <b>Irene Gaspari</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-32-1610</b>	
17. INFORMANT <b>C. Preston Scheffenacker, Jr.</b>				ADDRESS <b>305 Alleghany Ave.</b>	
18. <b>571.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <b>Probable paroxysmal cardiac arrhythmia</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Severe Laennec's cirrhosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>arteriosclerosis</b> (C) _____	
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Years</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>581.1 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>11-2-67</b> to <b>4-27-1968</b> , that (1) (we) last saw the deceased alive on <b>3-29-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>RK Gundry</b>				23B. DATE SIGNED <b>4/29/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Richard K. Gundry</b>				23D. ADDRESS <b>2 W. University Parkway</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/30/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairley</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>	
				ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 4557
68- 4557 CERTIFICATE OF DEATH				REG. NO.
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MRS. MAGGIE L. LEE</b>		
2. DATE AND HOUR OF DEATH <b>4/28/68 10:23p</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>MARYLAND GENERAL HOSPITAL</b>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		5. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		
6. STREET AND NUMBER <b>514 WYANOKHE AVE.</b>		7. SEX <b>FEMALE</b> RACE <b>WHITE</b>		
8. DATE OF BIRTH <b>10/4/87</b>		9. AGE (In years last birthday) <b>80</b>		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(NONE) HOUSEWIFE-OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>PHILIP DISNEY</b>		
14. MOTHER'S MAIDEN NAME <b>MARY WATTS</b>		15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>215-32-3494B</b>		17. INFORMANT <b>FRANK D. LEE</b> ADDRESS <b>6637 LOCH HILL Rd. - 21212</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CARDIOGENIC Shock</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 to</b>		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarction extensive</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD extensive</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II Pulmonary Edema</b>		(C) <b>Pulmonary Edema</b>		
19A. DATE OF OPERATION <b>4/22/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>HEART BLOCK</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>4/22</b> 19 <b>68</b> to <b>4/28</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>4/28</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>[Signature]</b> DEGREE				23B. DATE SIGNED <b>4/28/68</b>
23C. PHYSICIAN'S NAME (Type) <b>DR. SAYLOR</b>				23D. ADDRESS <b>Maryland General Hospital</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/2/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Mark's Epis. Church Cem. Highlane, Maryland</b>
24D. LOCATION (City, town, or county) (State) <b>Balto. 12, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 68- 4558			
17-632 68- 4558													
BIRTH NO.													
1. NAME OF DECEASED (Type or Print) <b>Harry E. Martz</b>					2. DATE AND HOUR OF DEATH <b>April 29, 1968 6 A. M.</b>								
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3309 Westerwald Ave.</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3309 Westerwald Ave.</b>								
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/19/1891</b>		9. AGE (In years last birthday) <b>76</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Western Union &amp; B&amp;O RR</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>Communications</b>					11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Francis E. Martz</b>					14. MOTHER'S MAIDEN NAME <b>Fietta A. Garner</b>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>091-07-2018</b>		17. INFORMANT <b>Mrs. Mary A. Martz</b>			ADDRESS (Same)			
18. <b>4122 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio-Vascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
19. <b>443X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Hypertension</b>										years?			
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <input checked="" type="checkbox"/>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 10, 1966</b> to <b>April 29, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 27, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <b>Frank N. Ogden M.D.</b>								23B. DATE SIGNED <b>April 30, 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Frank N. Ogden</b>			
23D. ADDRESS <b>2701 N. Calvert St.</b>								23E. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd Balto. 12, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/3/1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Church of Brethern Sugar Valley Congregation</b>				24D. LOCATION (City, town, or county) (State) <b>Loganton, Pa.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>				25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>					

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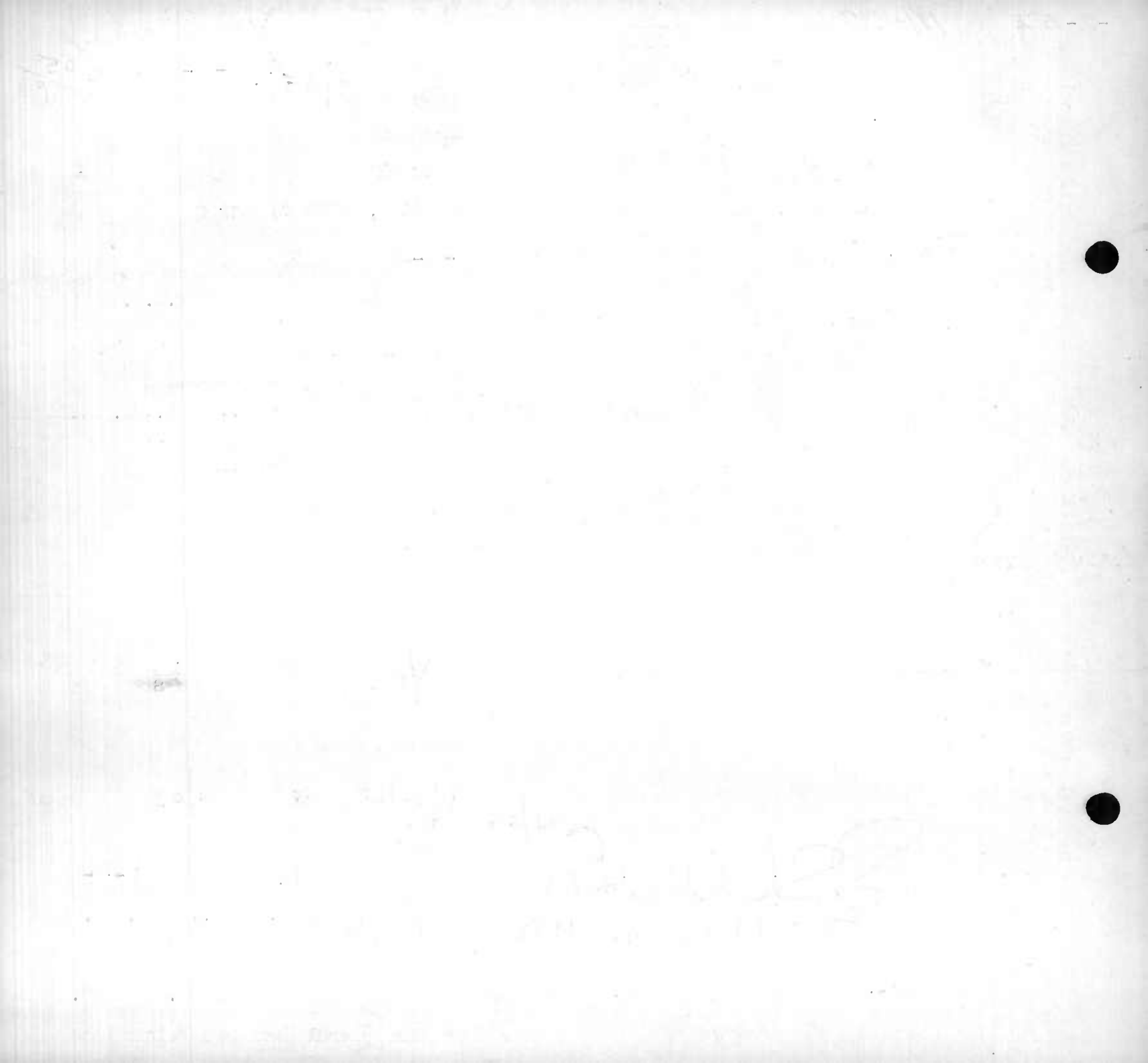
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 11-600				68-4559				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4559			
1. NAME OF DECEASED (Type or Print) <b>James Myer</b>				JAMES MYER				2. DATE AND HOUR OF DEATH <b>4/25/68 9:05 P.M.</b>				4-25-68			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>								C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <b>BOX 501 A, ROUTE 16 21220</b>															
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-27-09</b>		9. AGE (In years last birthday) <b>58</b>		If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Home Repair Work</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>WILLIAM Myer</b>								14. MOTHER'S MAIDEN NAME <b>LENA - unknown</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>013-03-2280</b>				17. INFORMANT <b>RECORDS: BALTIMORE CITY HOSPITALS</b>				ADDRESS <b>4940 EASTERN AVE., BALTO., MD. 21224</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>MI</b>								CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.															
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II</b>															
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>Yes</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>4/25/68</b> 19 <b>68</b> to <b>4/25</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/25</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE <b>J.S. Urbane</b>								23B. DATE SIGNED <b>4-25-68</b>							
23C. PHYSICIAN'S NAME (Type) <b>J.S. Urbane M.D.</b>								23D. ADDRESS <b>Baltimore City Hosp.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>4-29-1968</b>				24C. NAME OF CEMETERY or CREMATORY <b>Ebenezer Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>				25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road</b>				ADDRESS <b>21236</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
C-500 68-4560 CERTIFICATE OF DEATH									
REG. NO. 68-4560									
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>CITANEY, Gilbert Edward</i>				2. DATE AND HOUR OF DEATH <i>4-19-68 1105 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University of Md. Hosp.</i>						A. STATE <i>Md</i>		B. COUNTY <i>Prince George's</i>	
						C. CITY OR TOWN <i>Land</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>304 2nd Street 66-00</i>									
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-24-02</i>		9. AGE (In years last birthday) <i>66</i>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labarer</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel E. Citaney</i>				14. MOTHER'S MAIDEN NAME <i>Anne Whittemore</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Bessie Chaney Abane</i>			
18. <i>162.1 I</i> CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of the lung</i>									
(B) DUE TO, OR AS A CONSEQUENCE OF:									
(C) DUE TO, OR AS A CONSEQUENCE OF:									
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not White At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>April 19 1968</i> to <i>April 19 1968</i> , that (I) (we) last saw the deceased alive on <i>18 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Wm. J. Sander</i>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4-19-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Michael H. Gorman</i>						23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-23-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cornet Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Thurmont Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 30 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>DeWitt Danielson Land Md</i>					

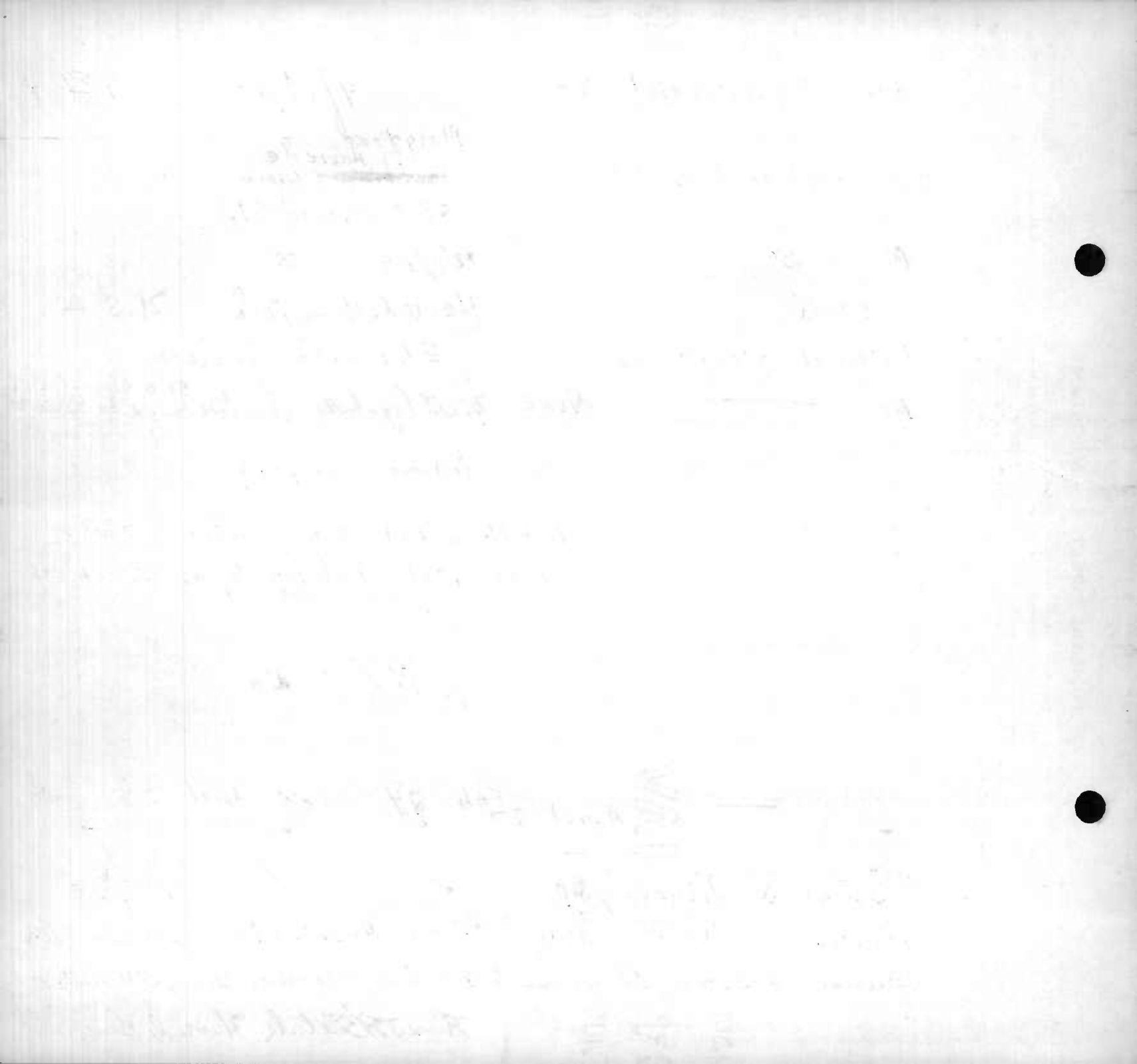


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <b>68-4561</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>5-363 68-4561</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>						<div style="display: flex; justify-content: space-between;"> <span><b>BIRTH NO.</b> <i>Harre de Grace, Md.</i></span> <span><b>REG. NO.</b> <b>68-4561</b></span> </div>	
1. NAME OF DECEASED (Type or Print) <b>Stewart, Nathaniel Jr</b>			2. DATE AND HOUR OF DEATH <b>4/27/68 1:59 P.M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Harford Co</b>				
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>			C. CITY OR TOWN <b>Harre de</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33</b>			E. STREET AND NUMBER <b>553 Girard St.</b>				
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/7/64</b>	9. AGE (In years last birthday) <b>3</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>			11. BIRTH PLACE (State or foreign country) <b>Harre de Grace, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
13. FATHER'S NAME <b>Nathaniel Stewart Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Jones</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Elizabeth Stewart</b>		
18. <b>065X I</b>			ADDRESS <b>553 Girard St. Harre de Grace, Md</b>				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>082.3 II</b>			CAUSE OF DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>Probable Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF:				
			(B) <b>Probable viral encephalitis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2 mos</b>				
			(C) <b>Congenital Rubella Syn.</b> DUE TO, OR AS A CONSEQUENCE OF: <b>from birth</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 24 1968</b> to <b>April 27 1968</b> , that (I) (we) lost saw the deceased alive on <b>April 27 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Martin G. Myers, MD</b>				23B. DATE SIGNED <b>4/27/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>Martin G. Myers MD</b>				23D. ADDRESS <b>Johns Hopkins Hosp. Baltimore Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-30-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. James G. M. E. Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Harre de Grace, Harford Co, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>R. E. F. F. F.</b>		25C. FUNERAL DIRECTOR <b>James T. Bulluck</b>			
				ADDRESS <b>Harre de Grace, Md</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68-4562</span>	
<div style="display: flex; justify-content: space-between;"> <span>11-625 68-4562</span> <span style="font-size: 1.2em;">17-625 68-4562</span> </div>					
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>            1. NAME OF DECEASED            (Type or Print) <span style="font-size: 1.1em;">PRIMO C. MORGANTI</span> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>            April 29, 1968 <span style="font-size: 1.1em;">13.30 A.M.</span> </div> </div>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.1em;">1622 Northgate Road</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.1em;">Baltimore</span> <b>5. STREET AND NUMBER</b> <span style="font-size: 1.1em;">1622 Northgate Road</span>		
<b>5. SEX</b> <span style="font-size: 1.1em;">male</span> <b>6. RACE</b> <span style="font-size: 1.1em;">caucasian</span> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <span style="font-size: 1.1em;">April 1, 1896</span> <b>9. AGE</b> (In years last birthday) <span style="font-size: 1.1em;">72</span> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.1em;">Italy</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.1em;">U.S.A.</span>
<b>13. FATHER'S NAME</b> <span style="font-size: 1.1em;">Julio Morganti</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.1em;">Cladia ?</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">No</span>			<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.1em;">212-09-6223</span>		<b>17. INFORMANT</b> <span style="font-size: 1.1em;">Mary Morganti</span> <b>ADDRESS</b> <span style="font-size: 1.1em;">Same</span>
<b>18. 162.1 I</b> <b>CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Carcinomatosis</span> <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">Bronchogenic Carcinoma</span> <b>(B) DUE TO, OR AS A CONSEQUENCE OF</b> <span style="font-size: 1.2em;">Lung cancer</span> <b>(C)</b>					
<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">April 1968</span> <span style="font-size: 1.2em;">April 1966</span>					
<b>162.1 II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.1em;">4/25/68</span> <b>to</b> <span style="font-size: 1.1em;">4/29/68</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.1em;">4/25/68</span> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">[Signature]</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">4/29/68</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.1em;">Dr. Emanuel S. Ellison</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.1em;">107 E. West St, Balto, Md.</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.1em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.1em;">4/5/2/68</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.1em;">Holy Redeemer</span>	
<b>24D. LOCATION</b> (City, town, or county) <span style="font-size: 1.1em;">Baltimore, Maryland</span>		<b>24E. STATE</b> <span style="font-size: 1.1em;">Maryland</span>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.1em;">APR 30 1968</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.1em;">Robert E. Fisher</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.1em;">Leonard J. Ruck, Inc, Balto, Md.</span>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

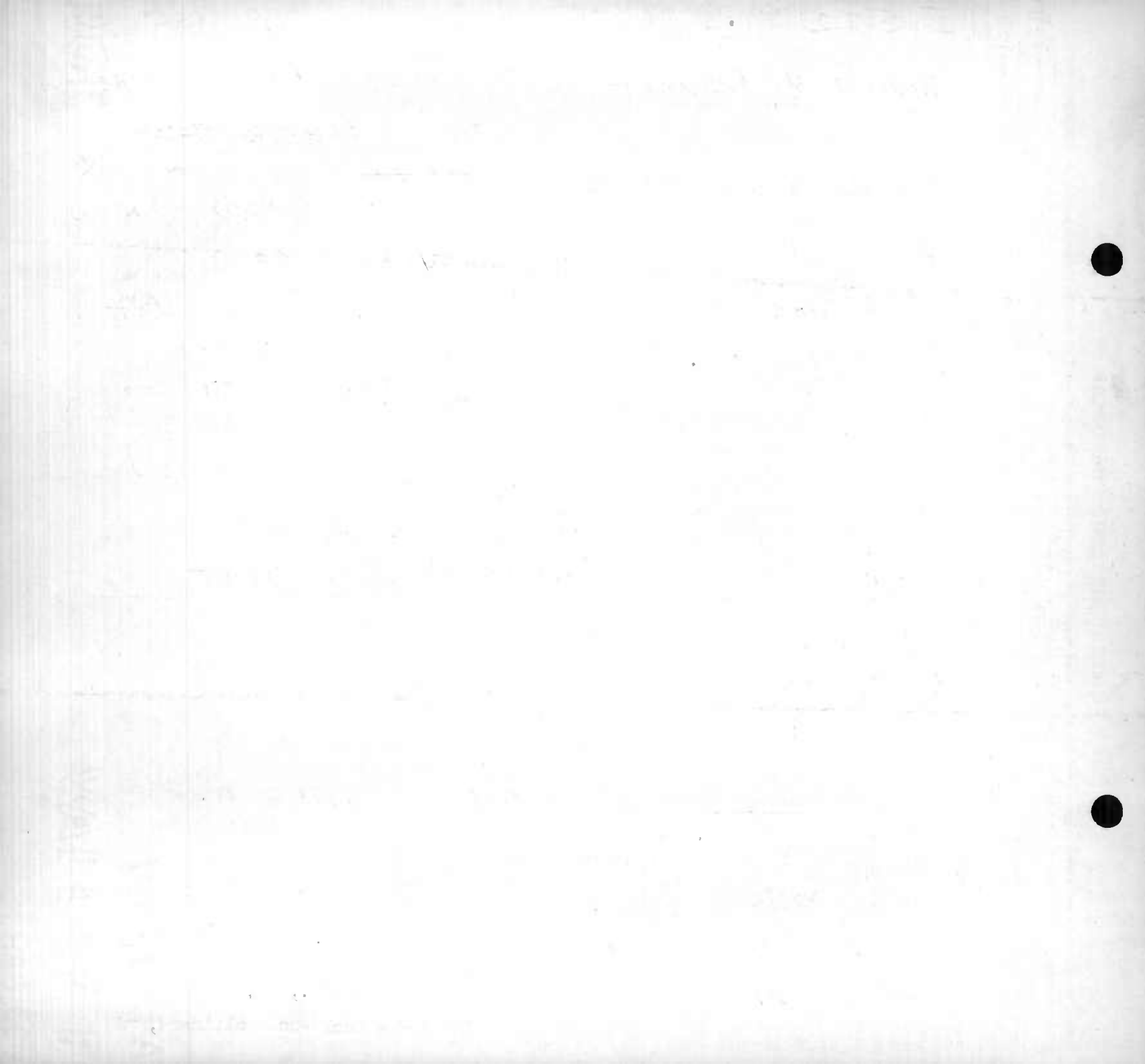
L-550 68-4563				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4563	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Lanahan, William J.</u>				2. DATE AND HOUR OF DEATH <u>4-29-68 10Pm</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Franklin Square Hospital</u> <u>900 N. Calhoun St. - Baltimore MD</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Calvert</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2307 E. Coldspring Lane</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-23-22-1912</u>	9. AGE (In years last birthday) <u>55</u>	10. Under 1 Yr. Months: <u>27</u> Days: <u>07</u>	11. Under 24 Hrs. Hours: <u>27</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superv.</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Employment Security</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William J. Lanahan</u>				14. MOTHER'S MAIDEN NAME <u>Rose Mc Govern</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW2 NAVY</u>				16. SOCIAL SECURITY NO. <u>219078477</u>		17. INFORMANT ADDRESS <u>Rose Pacunas, 4400 Mainfield Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <u>Terminal pneumonia</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>560.5 II</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Terminal pneumonia</u>			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Internal hernia</u>							
19A. DATE OF OPERATION <u>4-25-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Internal hernia</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4-21-68</u> 19 to <u>4-29-68</u> 19, that (I) (we) last saw the deceased alive on <u>4-29-68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>April 29, 1968.</u>			
23C. PHYSICIAN'S NAME (Type) <u>M. AFZAL</u>				23D. ADDRESS <u>Franklin Square Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-2-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 30 1968</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4564
BIRTH NO. 1-522		68-4564		68-4564
1. NAME OF DECEASED (Type or Print) FLORENCE H. INGOGLIA		2. DATE AND HOUR OF DEATH 28 APR 68 7:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN BENSON D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1911 HARFORD ROAD, BENSON		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-24	9. AGE (in years last birthday) 43
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RECEIVING CLERK		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN HILINSKI Sr.		
14. MOTHER'S MAIDEN NAME VERONICA GRUBOWSKI		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 220-24-7620		17. INFORMANT Salvatore M Ingoglia ADDRESS Same		
18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA, DECOMPENSATION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HEPATIC METASTASES (B) DUE TO, OR AS A CONSEQUENCE OF: ADENOCARCINOMA BREAST (C)				
19. 170 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0 none	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4-23 1968 to 4-28 1968, that (I) (we) last saw the deceased alive on 4-27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Sidney Stapleton, Jr MD DEGREE		23B. DATE SIGNED 28 Apr 68		23C. PHYSICIAN'S NAME (Type) SIDNEY STAPLETON, Jr MD DEGREE
23D. ADDRESS MARYLAND GENERAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5/2/68	24C. NAME OF CEMETERY or CREMATORY Parkwood	24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 30 1968	25B. NAME OF REGISTRAR Robert E. Talley	25C. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Md		





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4565	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>THOMAS MATTHEWS</b>		2. DATE AND HOUR OF DEATH <b>4-28-68 10:20 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>102 MADERIA ST (31)</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-2-94</b>	9. AGE (In years lost birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>JOSEPH MATTHEWS</b>			14. MOTHER'S MAIDEN NAME <b>MARY (UNKNOWN)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Augusta Murray</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PREMIE ACIDOSIS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>① CONGESTIVE heart failure</b> <b>② ACUTE TUBULAR NECROSIS (?)</b> <b>16'</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>603X II</b>			<b>BURNS OF FACE, SCALP &amp; @ HAND (?)</b> <b>20 MAY HAVE CONTRIBUTED</b>		
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOME</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>102 MADERIA ST (31)</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>4 22 68 (?)</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>BURNED FACE &amp; SCALP &amp; @ HAND</b> <b>1-20 - WILD</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>4-22-68</b> 19 <b>68</b> to <b>4-28</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-28-</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <b>Ricardo M. Turson M.D.</b>				23B. DATE SIGNED <b>4-28-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ricardo M. Turson</b>				23D. ADDRESS <b>Church Home &amp; Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-2-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn, Cal</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>					
25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Choy O. Wilson 1000 Crumpline</b>	

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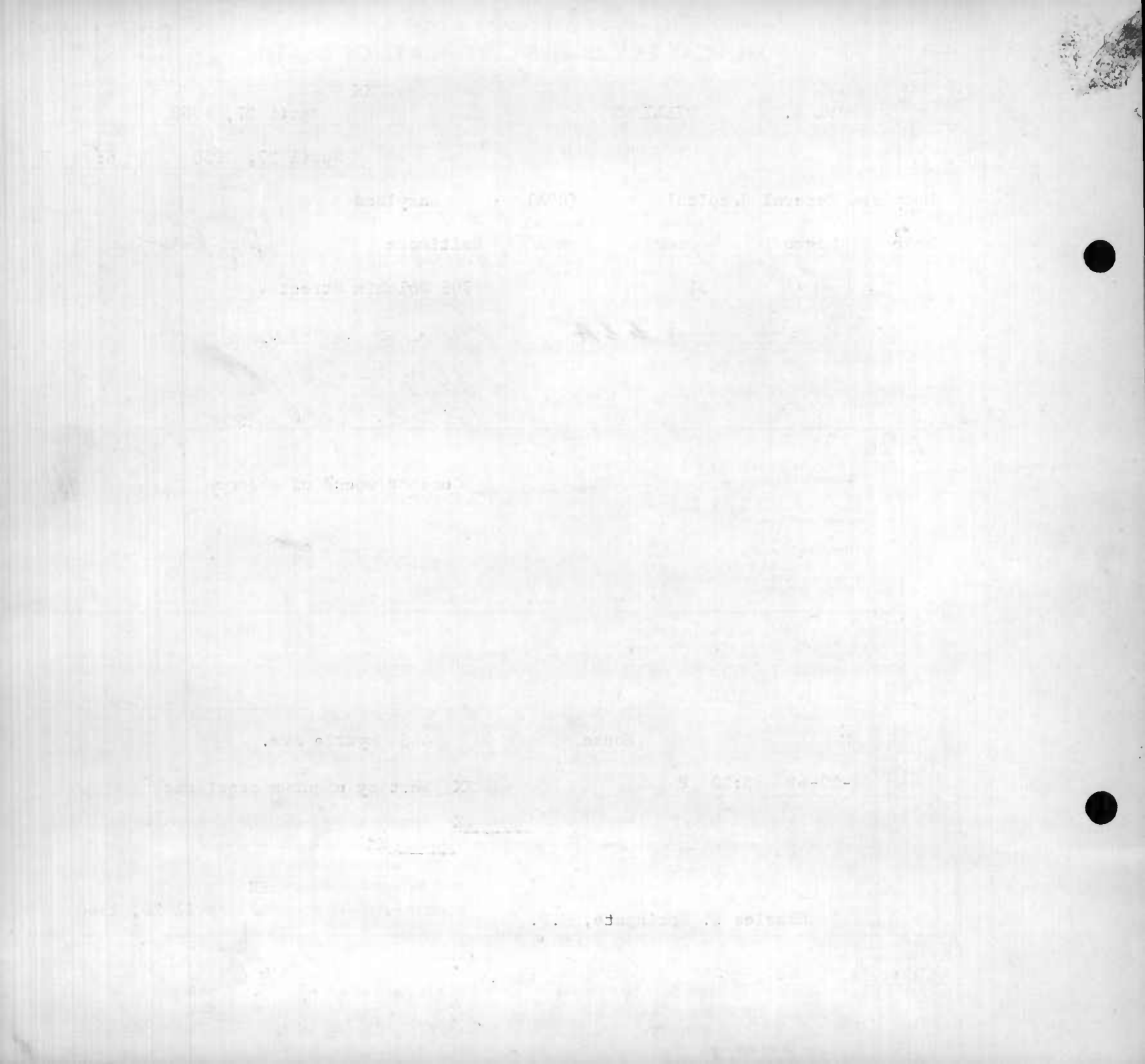
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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>PAUL A. WILLIAMS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>April 27, 1968</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Maryland General Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 27, 1968 6:00 P.M.</b>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
9. DATE OF BIRTH <b>May 11, 1937</b>		10. AGE (In years lost birthday) <b>31</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME <b>Alma Doney</b>		18. INFORMANT ADDRESS <b>Alma Williams</b>	
19. <b>E965X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of abdomen</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>	
22C. WHERE DID INJURY OCCUR? <b>415 Myrtle Ave.</b>		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>4-27-68 5:20 P</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 28, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-2-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Antietam</b>		24D. LOCATION (City, town, or county) (State) <b>Laurel Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>Thayer Wilson</b>		ADDRESS <b>1002 Brantley Rd</b>	



1  
M-655

68-4567 BALTIMORE CITY HEALTH DEPARTMENT

68-4567

(DUPLICATE)

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EUGENE MOORMAN . H

2. DATE  
OF  
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

00 165 W. Hamburg Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

April 28, 1968

9:35 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

27 Sep 08

10. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

9

E. STREET AND NUMBER

941 Sharp Street

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Chancellor Moorman

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cook

14B. KIND OF BUSINESS OR INDUSTRY

Va Hospital

15. MOTHER'S MAIDEN NAME

Ellen Hardy

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Susie Laws-941 Sharp Street

19. 412.4 I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 30, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

24B. DATE

5-1-68

24C. NAME OF CEMETERY or CREMATORY

Lynchburg

24D. LOCATION (City, town, or county)

Virginia

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAY 1 1968

R. E. G. F. J. J.

Isaiah L. Brown and Son  
123 W. Montgomery Street

MEMORANDUM FOR THE DIRECTOR

April 26, 1952

Subject:

Internal Security - Communist

Reference:

NY 100-100000

NY 100-100000

NY 100-100000

NY 100-100000

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CONFIDENTIAL

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NY 100-100000

BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>DOUGLAS CHARLES ANGEL</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>92 Baltimore City Jail</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 26, 1968 6:17 P.</b> M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>1225 W. Lombard Street</b>	
9. DATE OF BIRTH <b>Dec. 28, 1950</b>		10. AGE (In years last birthday) <b>17</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Luther Hilton Angel</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>assistant</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>home improvement</b>		15. MOTHER'S MAIDEN NAME <b>Lena F. Middleton</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>217-54-4119</b>		18. INFORMANT ADDRESS <b>Mrs. Lena F. Angel 1225 W. Lombard St.</b>			
19. CAUSE OF DEATH <b>E 9631 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Asphyxia</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hanging</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. DATE OF OPERATION <b>E 924X II</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Jail cell</b>			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Baltimore City Jail - Cell #328</b>				22F. HOW DID INJURY OCCUR? <b>Hanged self</b>			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>between 4:00 4-26-68 &amp; 4:45 P.m.</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				23. ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 27, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/30/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Crest Lawn Gardens</b>		24D. LOCATION (City, town, or county) (State) <b>Howard County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Walters Funeral Home Pratt &amp; Stricker Sts.</b>			



UNITED STATES

DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

February 1, 1954

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Sir:

Enclosed

WILLIAM

Call only - telephone 444-1000

Enclosed

Between 1940  
and 1945

UNITED STATES

DEPARTMENT OF JUSTICE

Division of Investigation

Enclosed

Enclosed

Enclosed

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-4569
4-155 68-4569		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>ALBERT J. HOFFMAN</b>		2. DATE AND HOUR OF DEATH <b>4/29/68 10<sup>05</sup> A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>44 BALTO. 21218</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b>		
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-19-25</b> 9. AGE (In years last birthday) <b>42</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		11. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>BOTH. STEEL</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JUAN A. HOFFMAN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN Elizabeth Tallaksen</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN WWII</b>		16. SOCIAL SECURITY NO. <b>40748-8172</b>		
17. INFORMANT <b>MRS. MOULIE HOFFMAN</b>		ADDRESS <b>641 Arch Fre Rd</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>157.8 I S.S. #212-20-4146</b> <b>(212-20-4146) Carcinoma of trile of pancreas</b> <b>respirator insufficiency</b> <b>Carcinoma tons</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>157X II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma tons</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>C. K. W.</b> (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>157X II</b>				
19A. DATE OF OPERATION <b>4/26</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA ?</b>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <b>4/26</b> to <b>4/29</b> 19 <b>68</b> to <b>4/29</b> 19 <b>68</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>P. Dickson Jones</b>		23B. DATE SIGNED <b>4/29/68</b>		23C. PHYSICIAN'S NAME (Type) <b>P. DICKSON JONES</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 3, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>OAK Lawn Cemetery</b>
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State) _____		
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Philip E. Crandall</b>
				ADDRESS <b>1211 Chesaw Ave.</b>

4/20c

2-10-52 45

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-4570
4-314 68-4570		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>BABY BOY HATFIELD (MICHAEL J. HATFIELD)</b>		2. DATE AND HOUR OF DEATH <b>4-28-68 9:30 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSP. SINAI HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>MIDDLE RIVER</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>521 CRISFIELD RD. #20</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-23-68</b>	9. AGE (In years lost birthday) <b>5 days</b>	If Under 1 Yr. Months: <b>5</b> Days: <b>5</b> If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>LANNY G. HATFIELD</b>		14. MOTHER'S MAIDEN NAME <b>MARY DAWSON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>A. Greenberg</b> ADDRESS <b>SINAI HOSP.</b>	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASPIRATION PNEUMONIA</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 days</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>763X II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21C. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21E. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-23</b> 19 <b>68</b> to <b>4-28</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-28</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="radio"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. Greenberg</b>		23B. DATE SIGNED <b>4-28-68</b>		23C. PHYSICIAN'S NAME (Type) <b>A. H. GREENBERG</b>	
23D. ADDRESS <b>SINAI HOSP.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>4-29-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>SACRED HEART CEM.</b>		24D. LOCATION (City, town, or county) <b>7401 GERMAN HILL RD. BALTO. CO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Charles S. Jailer</b> ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b>	

MARK DAWSON

BALTIMORE MD

4-23-68

221 CRISTFORD RD.

LANNY G. HATFIELD

INFANT

MALE WHITE

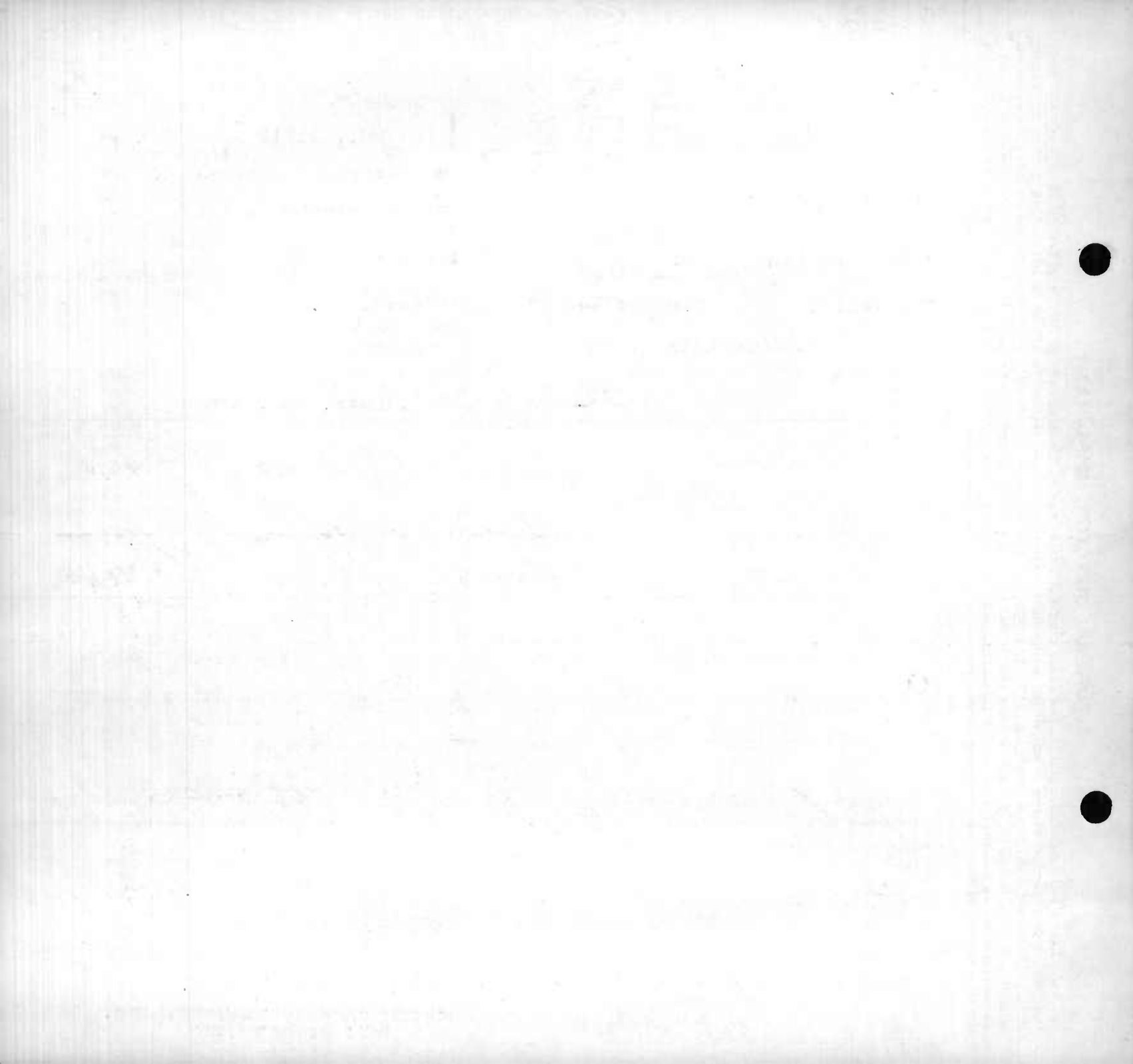
NO

BURIAL 4-28-68 SACRAMENTO HEART CEM. 3401 CLAYMAN HILL RD. NO. 10  
LANNY G. HATFIELD

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
L-320 68-4571 <b>CERTIFICATE OF DEATH</b>				68-4571	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Dr. John G. Lutz George		4-18-68 5:10 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
				A. STATE B. COUNTY	
				Md., 21213	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN	
37 Mercy				Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				3100 Kentucky Avenue	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7/16/1901	66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Pharmacist		Own Business		Baltimore, Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Francis Lutz				unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		214-34-4654		John A. Lutz, son, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
19. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 26 Apr 1968 to 25 Apr 1968, that (1) (we) last saw the deceased alive on 29 Apr 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				29 Apr 68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				Mary Bry.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5/2/68		Loudon Park Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 1 1968		Robert E. Fairbank		Schimunek Funeral Home, Inc. 3331 Brehms Lane	

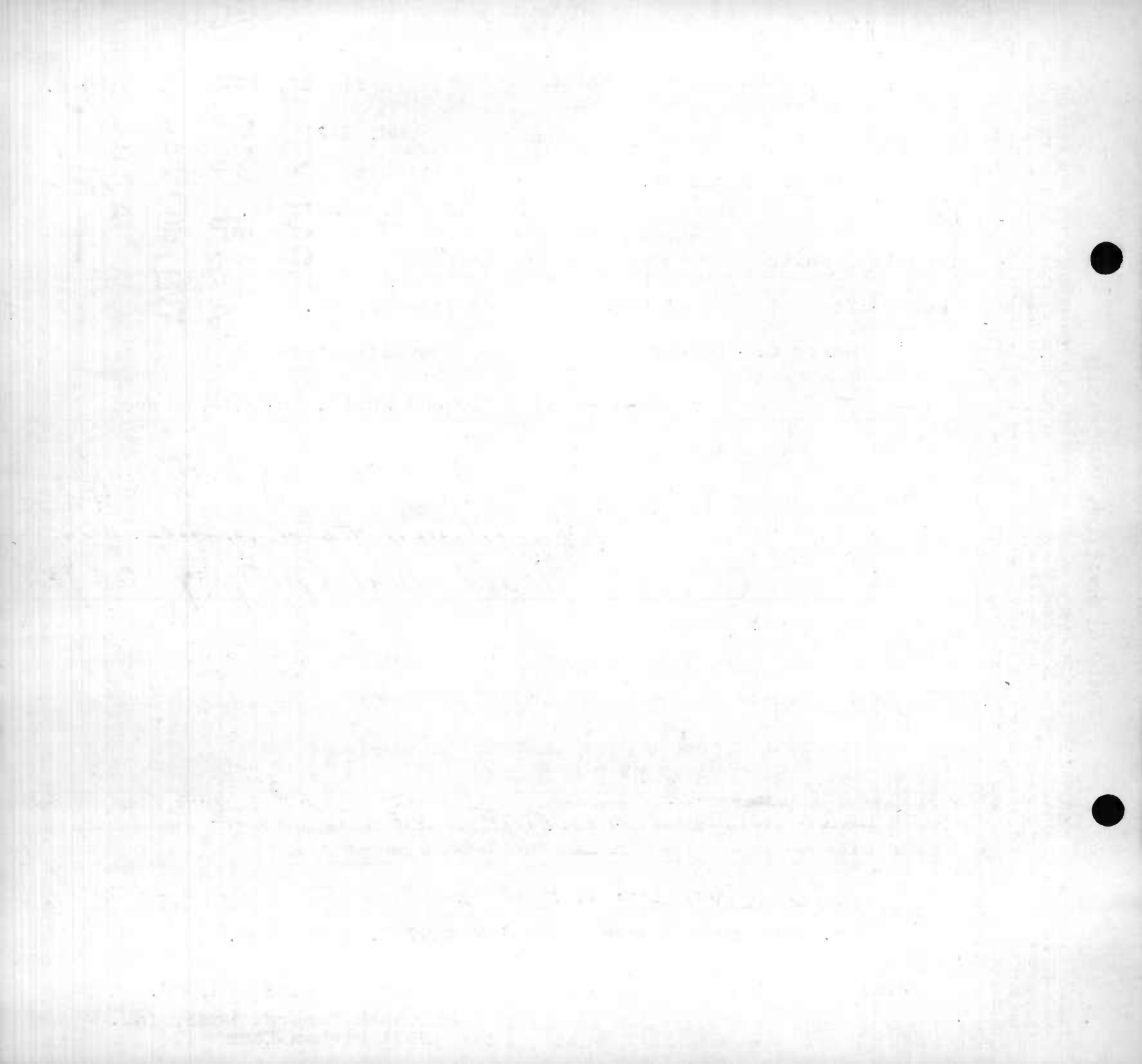




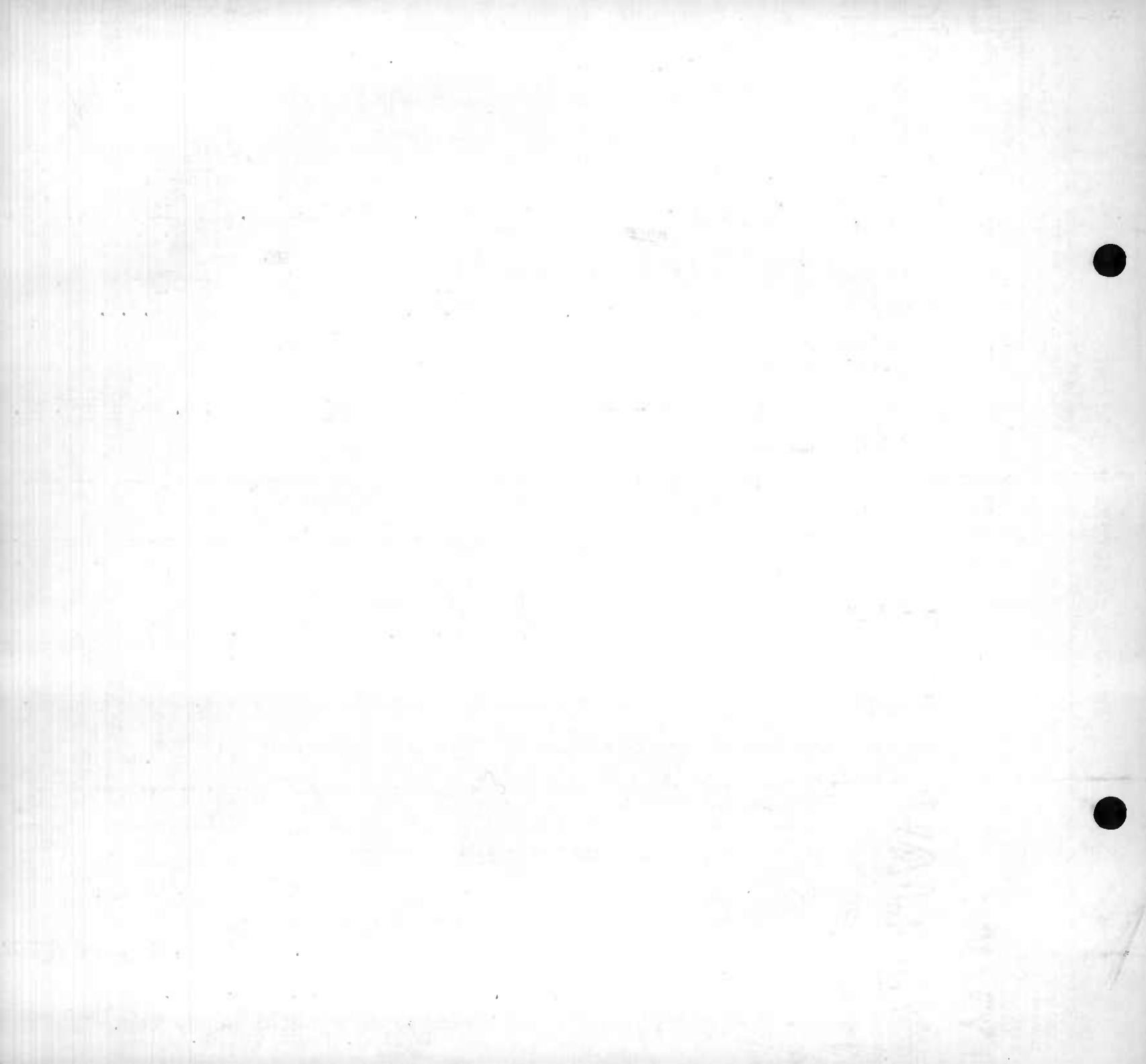
# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68- 4572</span>
BIRTH NO. <span style="float: right;">N-400</span>		68- 4572 <b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>NORA VIRGINIA NAILL</b>		2. DATE AND HOUR OF DEATH <b>April 28, 1968 9:20 p. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md. 21213</b> B. COUNTY <b>S-04</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2308 E. Biddle St.</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <b>2308 E. Biddle St.</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/2/1900</b>	9. AGE (In years last birthday) <b>68</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Harry C. Clocker</b>		
14. MOTHER'S MAIDEN NAME <b>Sovilla Stees</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>219-18-0739</b>		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Raymond Naill, husband, above</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) <b>34571 I</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Coronary Insufficiency</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertensive Cardiovascular Disease</i> (C) <i>Grand Mal Epilepsy 60 yrs.?</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>33-3.1 II</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <i>June</i> 19 <i>38</i> to <i>April</i> 19 <i>68</i> , that (I) <del>(we)</del> <i>have</i> seen the deceased alive on <i>March 1</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <i>(did)</i> (did not) view the body after death.				
23A. SIGNATURE <i>Isadore Grossman</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4/30/68</i>
23C. PHYSICIAN'S NAME (Type) <b>Dr. Isadore Grossman</b>		23D. ADDRESS <b>1527 <del>1507</del> E. North Ave.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/1/68</b>	24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-200		68-4574		BALTIMORE CITY DEPARTMENT		REG. NO. 68-4574	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>ELISWORTH E HAAS</b>			
2. DATE AND HOUR OF DEATH <b>4-28-68 8:10 A.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b>		B. COUNTY	
<b>00</b>		<b>3311 Hudson St.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3311 Hudson St.</b>		5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>8-16-1906</b>		9. AGE (In years lost birthday) <b>61</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance man.</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Christian</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Altvater</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>216-03-0610</b>		17. INFORMANT <b>Mrs. Gertrude Haas</b>		ADDRESS <b>3311 Hudson St.</b>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.2 I</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebrovascular Accident</b>		(B) Advanced Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:		(C) Hypertensive Arteriosclerotic Cerebrovascular Accident	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>443X II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>7-1-1962</b> to <b>4-28-1968</b> , that (I) (we) last saw the deceased alive on <b>3-20-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Juri Hinnno</b>		23B. DATE SIGNED <b>4-29-68</b>		23C. PHYSICIAN'S NAME (Type) <b>JURI HINNO, M.D.</b>		23D. ADDRESS <b>5002 Frankford Avenue, Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL, (Specify)		24B. DATE <b>5-1-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Helma D. Hoffmann</b>		ADDRESS <b>3218 Hudson St.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

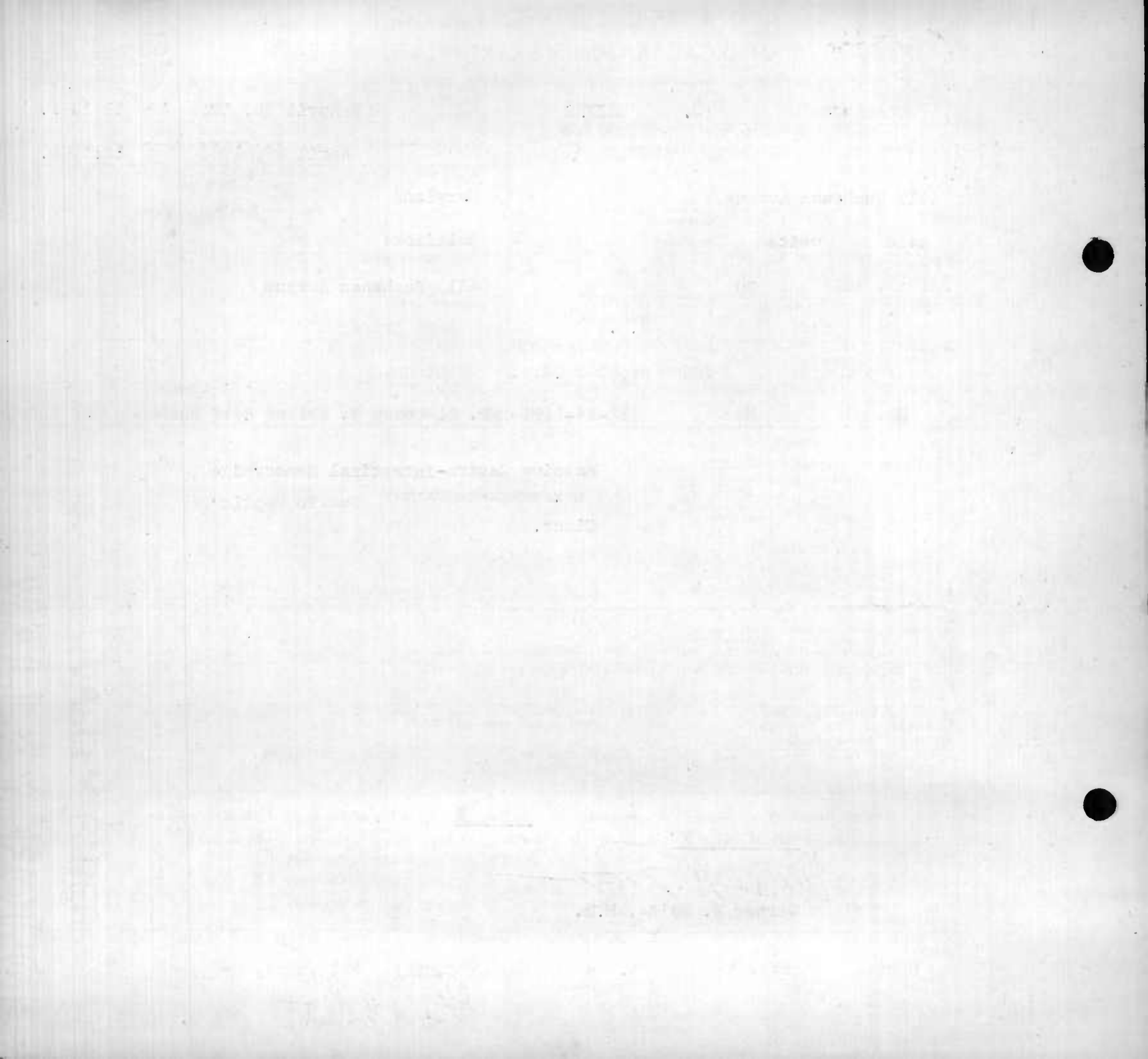
REG. NO.

68-4575

BIRTH NO.

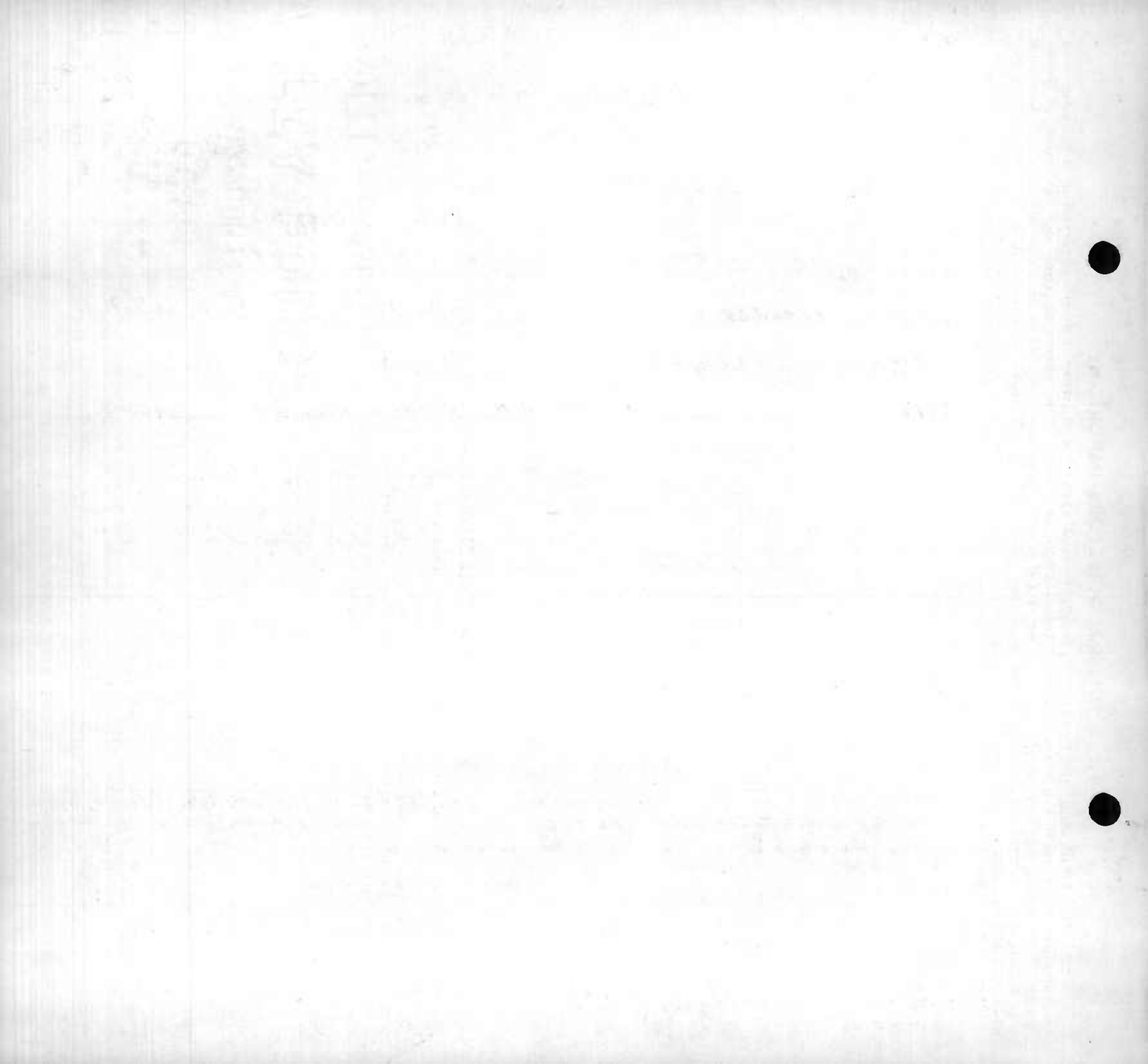
1. NAME OF DECEASED (Type or Print) <b>CLARENCE E.W. KRIKER</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 28, 1968</b> Hour <b>11:10 A.M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>4417 Buchanan Avenue</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 28, 1968 11:10 A.M.</b>			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-15</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>male</b>		7. RACE <b>white</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		E. STREET AND NUMBER <b>4417 Buchanan Avenue</b>	
9. DATE OF BIRTH <b>Jul 15, 1897</b>		10. AGE (In years last birthday) <b>70</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grounds Keeper</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Johns Hopkins Univ.</b>		15. MOTHER'S MAIDEN NAME <b>Stennier</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>212-14-1194</b>		18. INFORMANT ADDRESS <b>Mr. Clarence W. Kriker 4417 Buchanan Ave 21211</b>			
19. <b>531.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Massive Gastro-Intestinal Hemorrhage</b> (A) IMMEDIATE CAUSE <b>Due To Peptic Ulcer.</b> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>540.0</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>4/29/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-1-1968</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Marys Cem. (Hampden)</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REG'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Felsky</b>		25C. FUNERAL DIRECTOR <b>Frank A. Sauty</b>		ADDRESS <b>814 W. 36 St 21211</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

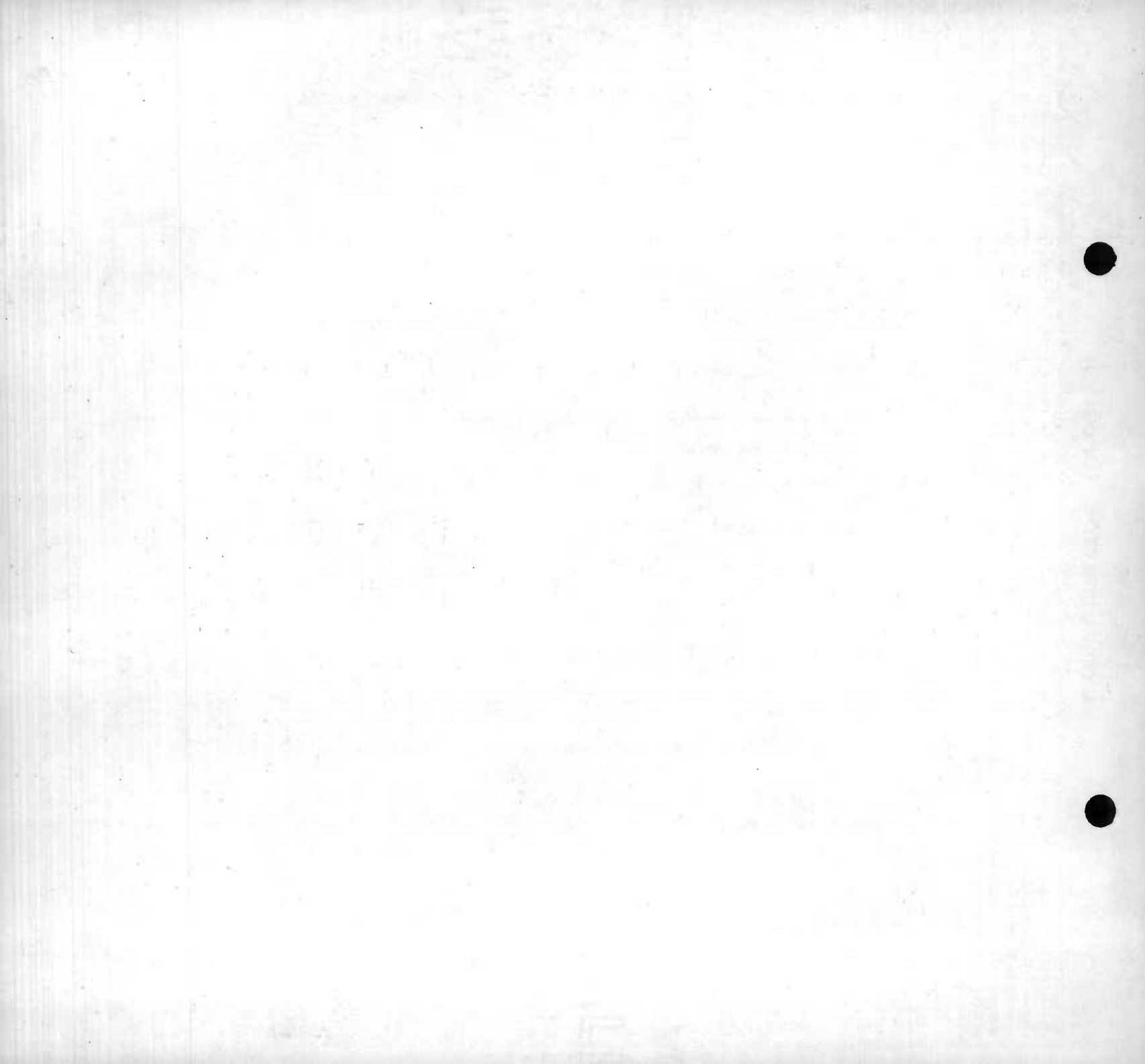
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4576</b>
K-500		68-4576		CERTIFICATE OF DEATH
BIRTH NO. _____				
1. NAME OF DECEASED (Type or Print) <b>MYRA KIMMEY</b>			2. DATE AND HOUR OF DEATH <b>4-28-68</b> <b>9<sup>00</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>5709 Adleigh Ave. #6</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-27-86</b>	9. AGE (In years last birthday) <b>81</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL TEACHER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MD</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>THOMAS FLOWERS</b>		
14. MOTHER'S MAIDEN NAME <b>MYRA FORD</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>VNK</b>		
16. SOCIAL SECURITY NO. <b>217-03-20507</b>		17. INFORMANT <b>DONALD KIMMEY</b> ADDRESS <b>ABOVE</b>		
18. CAUSE OF DEATH <b>157.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE: Carcinomatosis of abdomen</b> <b>(B) Carcinoma of the head of pancreas</b> <b>(C)</b>				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>157X II</b> <b>Intestinal obstruction</b>				
19A. DATE OF OPERATION <b>3/26/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal obstruction</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>297</b>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>4/26/68</b> 19 to <b>4/28/68</b> 19, that (I) (we) last saw the deceased alive on <b>4/27/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Pariiz Khojeh Amiri</b>			23B. DATE SIGNED <b>4/28/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Pariiz Khojeh Amiri</b>			23D. ADDRESS <b>Mercy Hospital, Balto, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>5/1/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>GARDENS OF FAITH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>J. J. Connelly Sons</b> ADDRESS <b>300 Nace Ave.</b>



# FUNERAL DIRECTOR: IMPORTANT

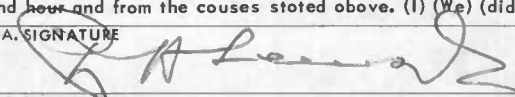
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

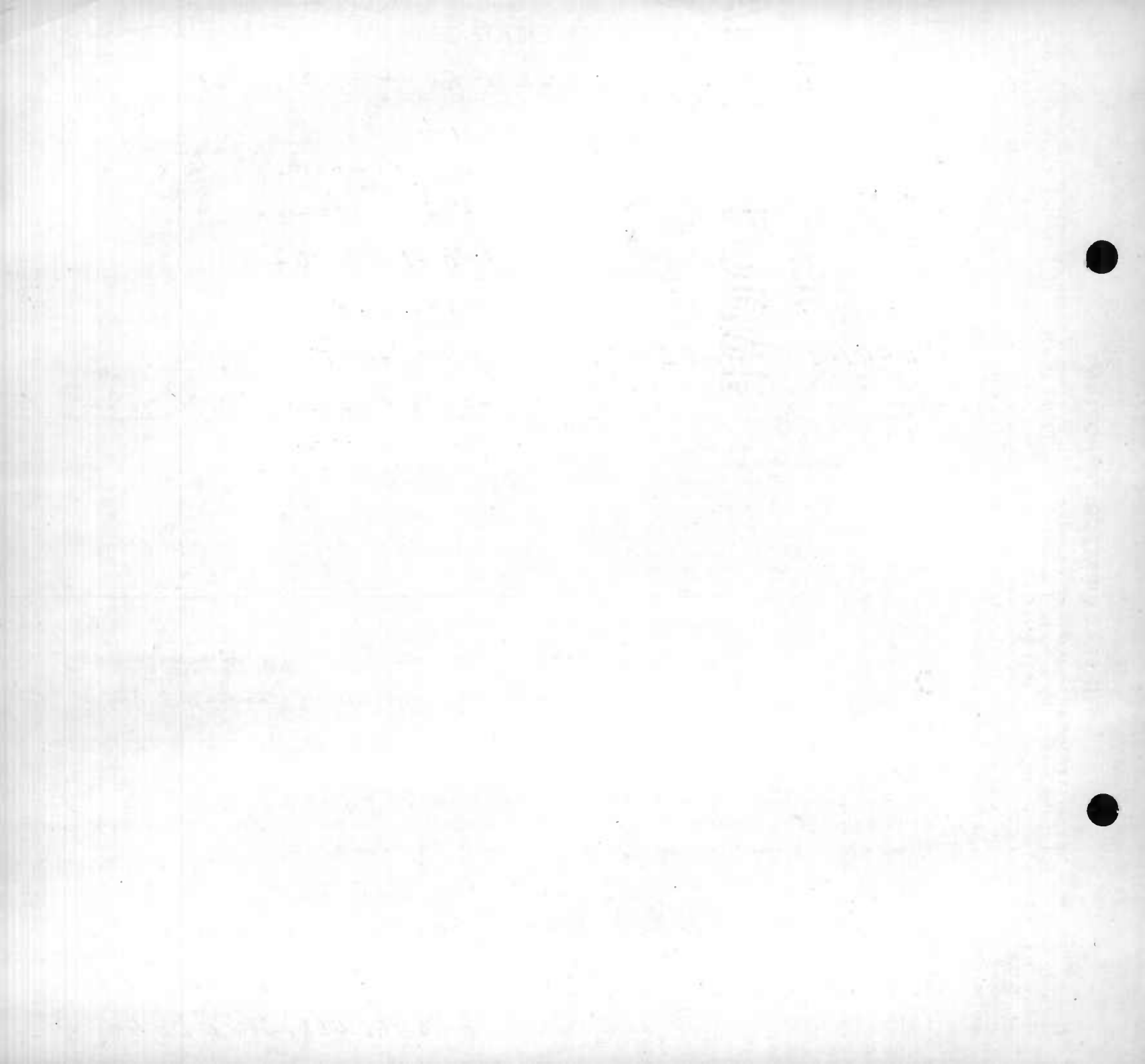
C-220 68-4577		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4577	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Vincent Czajkowski</i>		2. DATE AND HOUR OF DEATH <i>29 April 1968 12:20 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE FOUND DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>-</i>		5. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hspt</i>		6. DATE OF BIRTH <i>9/5/63</i>		9. AGE (In years lost birthday) <i>84</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BIRTHPLACE (State or foreign country) <i>Poland</i>	
5. SEX <i>M</i> 6. RACE <i>W</i>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired ?</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Steel worker? - NO</i>		13. FATHER'S NAME <i>? Kasimir</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Chant -</i>	
18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Renal failure</i>			
		(B) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
19A. DATE OF OPERATION <i>450.0 II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Chronic bronchitis</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/11</i> 19 <i>68</i> to <i>4/29</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/29</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Francis D. Drake, M.D.</i>		23B. DATE SIGNED <i>4/29/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Francis D. Drake, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-1-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Cross Cem.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 1 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jarboe, M.D.</i>		25C. FUNERAL DIRECTOR <i>John H. Hahn Funeral Hse - 4200 Pennington Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4578
F-626 68-4578		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>JOSEPHINE FRAZIER</b>		2. DATE AND HOUR OF DEATH <b>APR. 28, 1968</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
2719 ORLEANS ST.		E. STREET AND NUMBER <b>2719 ORLEANS ST.</b>		
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 29, 1905</b>	9. AGE (In years last birthday) <b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND.</b>
13. FATHER'S NAME <b>CHARLES TRABERT</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HARRY FRAZIER</b>
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CA RT. BREAST METASTASIS</b> (A) IMMEDIATE CAUSE TO BRAIN, LUNGS, LIVER DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>July 16, 1962</b> to <b>Apr 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>Apr 23, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED <b>4/29/68</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>ANDREW LEMICKA MD</b>		23D. ADDRESS <b>2608 E. BALTIMORE ST.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>4-30-68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEM.</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>	25C. FUNERAL DIRECTOR <b>B. DABROWSKI</b>		
		ADDRESS <b>1814 E. BALTO. ST.</b>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4579	
<div style="display: flex; justify-content: space-between;"> <span>68-4579</span> <span style="font-size: 2em;">B-220</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>1. NAME OF DECEASED (Type or Print) <u>Frank Beczkowski</u></span> <span>2. DATE AND HOUR OF DEATH <u>4-28-68</u> <u>5<sup>25</sup> P.M.</u></span> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 Church Home and Hosp</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> 8. COUNTY <u>Balt Co</u> <u>53-00</u> C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>7042 Bank St</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-15</u>	9. AGE (In years last birthday) <u>52</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Firemen</u>			11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Alexander Beczkowski</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Skobodzinski</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>213-10-3236</u>		17. INFORMANT ADDRESS
18. <u>199.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Metastatic carcinoma</u> <u>Few wk</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While AI <input type="checkbox"/> Not While AI Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-4</u> 19 <u>68</u> to <u>4-28</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-28</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Krishna Reddy</u>			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/28/68</u>
23C. PHYSICIAN'S NAME (Type) <u>KRISHNA REDDY</u>			23D. ADDRESS <u>Church Home &amp; Hosp.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>5-3-68</u>	24C. NAME OF CEMETERY or CREMATORY <u>St. Stanislaus Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Bd H &amp; O. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 1 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Talbot</u>		25C. FUNERAL DIRECTOR ADDRESS <u>BDADROWSKI 2445 E. BALTO. ST.</u>	

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Handwritten text in the middle section, including the words "Handwritten" and "Handwritten".

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ALFRED C. BRAXTON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 29, 1968</b> Hour <b>2:45 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 29, 1968 2:45 P.M.</b>	
6. SEX <b>male</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
7. RACE <b>negro</b>		C. CITY OR TOWN <b>Baltimore</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>9-1-45</b>		E. STREET AND NUMBER <b>1606 Division Street</b>	
10. AGE (In years lost birthday) <b>22</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Braxton</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Allie Braxton Brown</b>	
14B. KIND OF BUSINESS OR INDUSTRY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Allie Braxton</b>	
19. <b>309.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia Precipitated by</b> (A) IMMEDIATE CAUSE <del>HEAVY DRUG ABUSE</del> <b>Narcotic Addiction</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		ADDRESS <b>1606 Division St.</b>	
20A. DATE OF OPERATION <b>4-9-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>4/30/68</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>5-4-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>	
25B. NAME OF REGISTRAR <b>W. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Kelson Funeral Home 1348 Calhoun St.</b>	

WALLEY & SONS

25/10/16

X

1  
F-450

68- 4581 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 4581

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)  
GEORGE

FALLON FALLIN

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

April 28, 1968

11:30 P.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00541 Cumberland Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

April 28, 1968

11:30 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore m

YES ☒ NO ☐

6. SEX

male

7. RACE

negro

B. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

9. DATE OF BIRTH

1-17-09

10. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

512 Sanford Place

11. BIRTHPLACE (State or foreign country)

BALTO. MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

CHARLES FALLIN

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PORTER

14B. KIND OF BUSINESS OR INDUSTRY

B.C. Hosp.

15. MOTHER'S MAIDEN NAME

CORA PALMER

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

CORENA WARRINGTON 2421 Woodbrook AVE

19.

410.4

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

422.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

0

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

(Month)

(Day)

(Year)

(Hour)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/29/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

5/3/68

24C. NAME OF CEMETERY or CREMATORY

Balto. National

24D. LOCATION

(City, town, or county)

(State)

5501 FREDERICK AVE

25A. DATE REC'D BY HEALTH DEPT.

MAY 1 1968

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

ADDRESS

Joseph G. Lockyer 1304 N. Central Ave

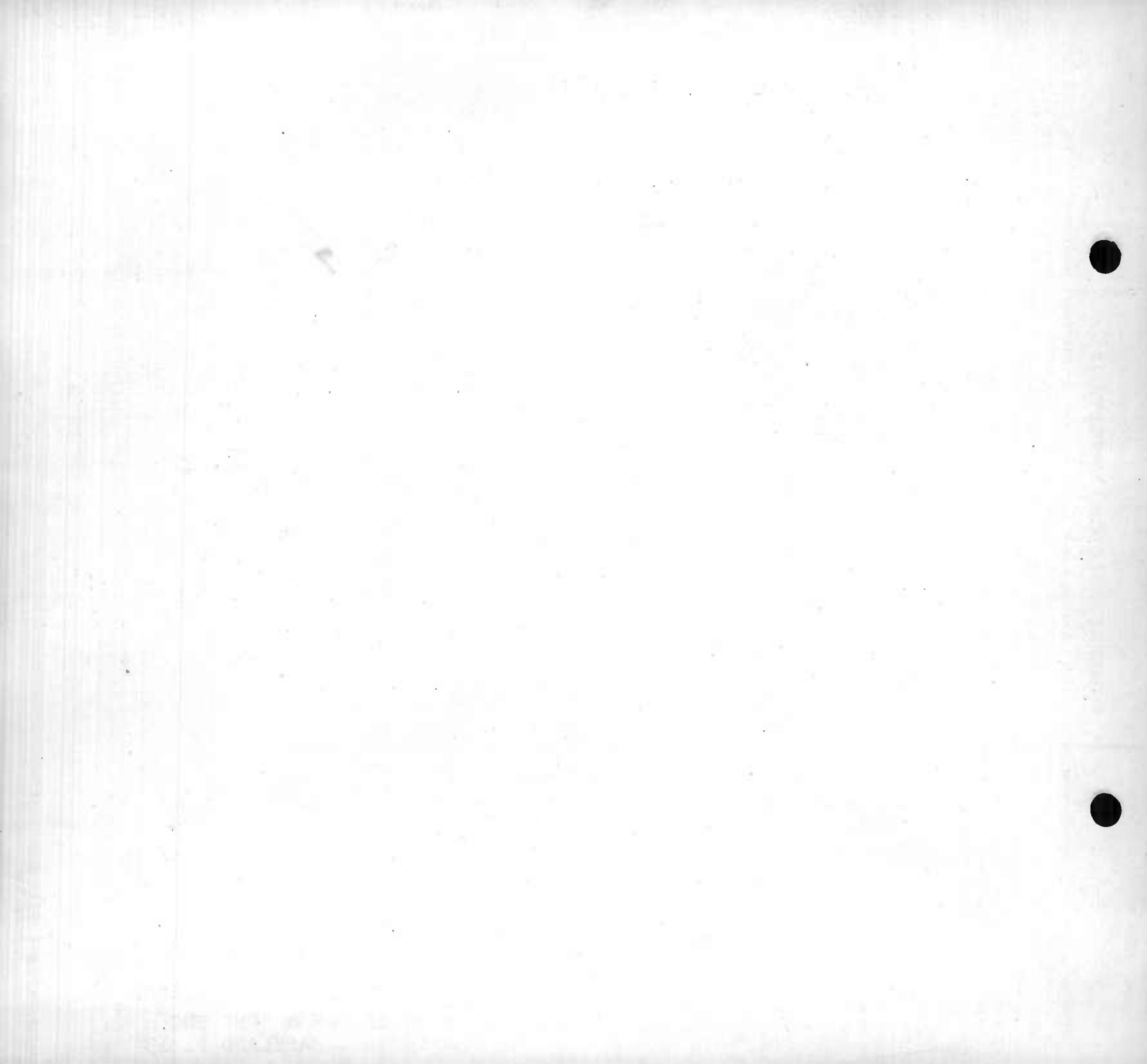


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4582	
<p><b>68- 4582</b> <b>CERTIFICATE OF DEATH</b></p>					
BIRTH NO.		1. NAME OF DECEASED <b>HARRY ELLSWORTH DALLMUS</b> (Type or Print) <b>HARRY DALLMUS</b>		2. DATE AND HOUR OF DEATH <b>4-28-68</b> <b>7<sup>10</sup> A.M.</b>	
3. PLACE IN <b>BALTIMORE, MARYLAND</b> , WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 MARYLAND General</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>915 Cator Ave</b>		
5. SEX <b>Male</b>	6. RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-25-39</b>	9. AGE (In years last birthday) <b>29 XXX</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAGGAGE MASTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PENN. RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>Marysville PA.</b>	
13. FATHER'S NAME <b>John F. Dallmus</b>		14. MOTHER'S MAIDEN NAME <b>Kate Myers</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>712-07-8014</b>		17. INFORMANT <b>Mr. George T. Dallmus 3726 Kimble RD.</b> <b>Sister in Law</b>	
18. <b>153.1 + 150.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD. extensive</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pulmonary Edema</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Perforated Carcinoma Transverse Colon</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>153.1 II</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes Mellitus</b>		
19A. DATE OF OPERATION <b>None</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/19</b> 19 <b>68</b> to <b>4/28</b> 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4/28</b> 19 <b>68</b> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (and not) view the body after death.					
23A. SIGNATURE <b>C.E. DeFelia</b>				23B. DATE SIGNED <b>4-28-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>C.E. DeFelia</b>				23D. ADDRESS <b>Md. General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 1, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park</b>	
24D. LOCATION <b>Baltimore Maryland</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jankowski</b>		25C. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS INC.</b>	
ADDRESS <b>BALTIMORE, MARYLAND 21213</b>					





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO. 68-4583

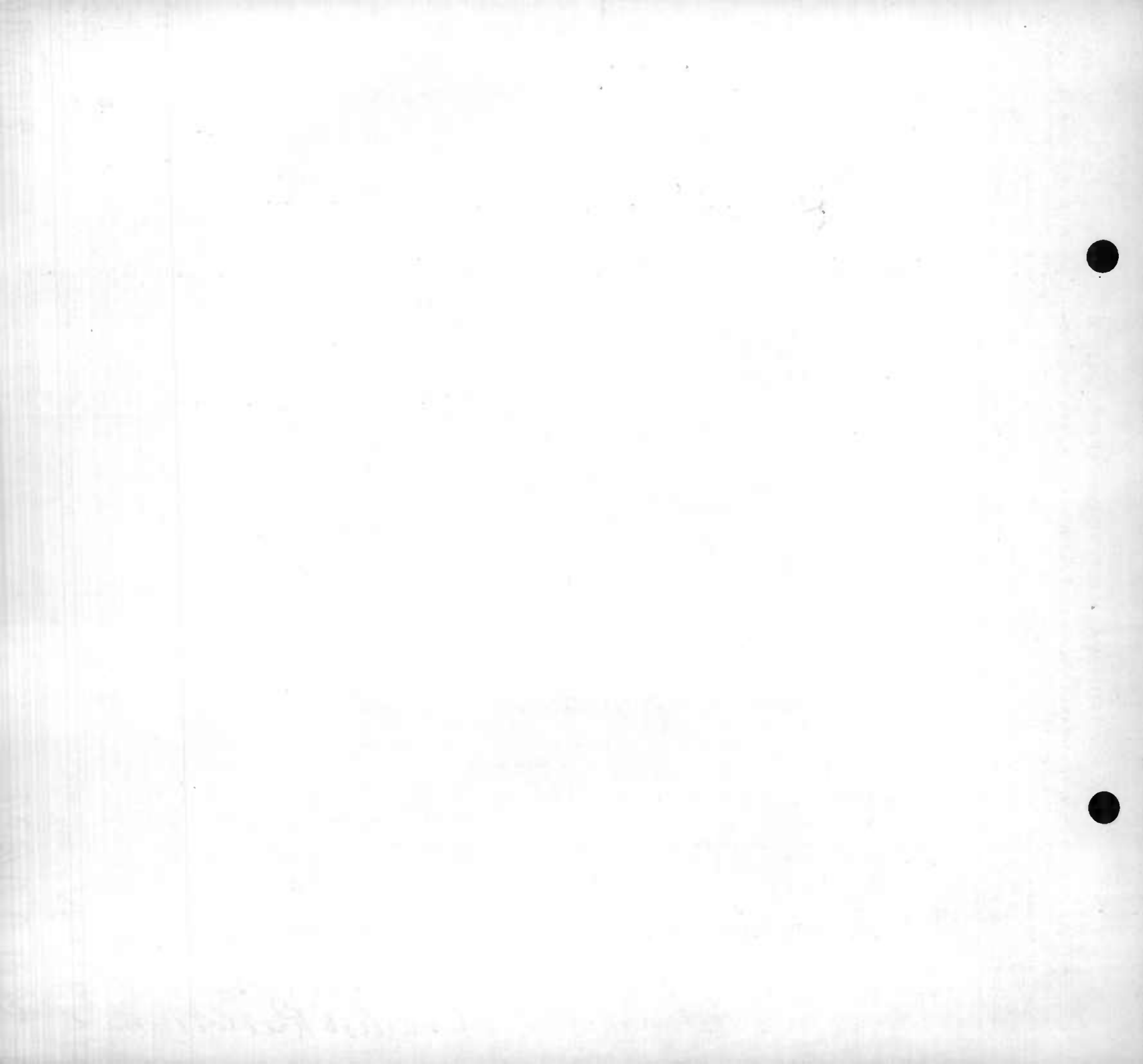
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Margaret Fields</b>		2. DATE AND HOUR OF DEATH <b>4-28-68 7:05</b> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2004</b>	
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAR MAID</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>10-5-24</b>	
13. FATHER'S NAME <b>Marley Fields</b>		14. MOTHER'S MAIDEN NAME <b>Ellie Brown</b>		9. AGE (In years last birthday) <b>43</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>68-4583</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ellie Fields 307 Stathorne St</b>	
18. <b>430.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Subarachnoid hemorrhage</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>330X II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Subarachnoid hemorrhage</b>			
		(B) <b>Cerebral aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>3/24/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Subarachnoid hemorrhage</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., at or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/18/68</b> to <b>4/28/68</b> , that (I) (we) last saw the deceased alive on <b>4/28/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Parviz Khojasteh</b>				23B. DATE SIGNED <b>4/29/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Parviz Khojasteh</b>				23D. ADDRESS <b>Mercy Hospital, Balt., MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/3/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Catholics Mem PK</b>	
24D. LOCATION (City, town, or county) (State) <b>Catholics MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Sisk</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		25D. ADDRESS <b>6614 W. Barks</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4584	
<div style="display: flex; justify-content: space-between;"> <span>51-00-60 ID</span> <span>68-4584</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MIAL, Ada J. <i>Mr. L. Ada J.</i>		4/28/68 5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224				MARYLAND	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 9. AGE (In years last birthday)				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
FEMALE NEGRO WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 11-28-92 75				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				E. STREET AND NUMBER	
				2401 TERRA FIRMA ROAD #21225	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
GREEN				SUSAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE MD	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: No Pul. embolism					
(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes; Hypertension					
(C) Uremia; CHF					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
260X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				YES	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/24/68 to 4/28/68 that (I) (we) last saw the deceased alive on 5:30 pm 4/28/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
David Juan M.D.				4/28/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DR. DAVID JUAN				BCH-4940 EASTERN AVENUE, BALTIMORE, MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/3/68		Baltimore National Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 1 1968		Robert E. Taylor, M.D.		Charles R. Rice 661 W. Barre St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4585

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4585

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>John Franklin Allen</b>		2. DATE AND HOUR OF DEATH <b>April 24, 1968 7:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-04</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>2012 N. Fulton Ave</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>Dec 2, 1898</b>	
13. FATHER'S NAME <b>Junius Allen</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Blye</b>		9. AGE (In years last birthday) <b>69</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <b>Buckingham, Va.</b>	
17. INFORMANT <b>Mrs. Lillian Jones</b>		ADDRESS <b>2012 N. Fulton Ave</b>		12. CITIZEN OF WHAT COUNTRY?	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Sec. Carcinoma</b> (B) <b>Pancreatic Ca.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Arteriosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several mths.</b> <b>Undetermined.</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>157X</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 2/67</b> 19 to <b>Apr 23</b> 1968, that (I) (we) last saw the deceased alive on <b>Apr 23/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles L. Comas</b>		23B. DATE SIGNED <b>Apr 28/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Charles L. Comas</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-30-68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Joseph L. Reeves</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. LOCATION (City, town, or county) <b>Baltimore</b>		24F. LOCATION (City, town, or county) <b>Baltimore</b>	

W. F. Gordon  
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112 W. F. Gordon



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4586

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4586

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Satterfield, Katherine Mae Gwaltney</b>		2. DATE AND HOUR OF DEATH <b>April 28 1968 2:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-11</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital Belv. Greenspring Ave</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>3906 Calloway Ave</b>		
5. SEX <b>F.</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 8 1904</b>	9. AGE (In years lost birthday) <b>64 Yrs.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Harry Satterfield</b>			14. MOTHER'S MAIDEN NAME <b>Webb</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-24-6890</b>		17. INFORMANT <b>Katherine Ann Gross 3906 Calloway Ave</b>	
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several Hrs.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Obesity</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>260x II</b>			(C) <b>Unknown</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2-17-1968</b> to <b>4-28-1968</b> , that (I) (we) last saw the deceased alive on <b>4-25-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard H. Hunt</b>				23B. DATE SIGNED <b>5/1/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard H. Hunt</b>				23D. ADDRESS <b>1607 W. Malbury St Balto. Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-2-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbtus Menorial Park</b>	
24D. LOCATION <b>Arbtus Maryland</b>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Donald E Glover 1701-03 Patterson Pkave</b>	



5-55268-4587 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. 68-4587

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN E. SIMMONS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 28, 1968 4:45 A.M.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
6. SEX <b>Male</b>	7. RACE <b>White</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>6/5/1904</b>		10. AGE (In years lost birth day) <b>64</b>		E. STREET AND NUMBER <b>3204 W. Belvedere Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>LOUISIANA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Kalib Simmons</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accounting</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Account.</b>		15. MOTHER'S MAIDEN NAME <b>Nora Dyer</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>431-09-8590</b>		18. INFORMANT <b>John Simmons Jr.</b>	
19. <b>E880X</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Subdural hematoma</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION <b>4-27-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Subdural hematoma</b>		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>3204 W. Belvedere 27-18</b>	
22D. TIME OF INJURY (APPROX.) <b>4-27-68 4:20 P.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Fell down stairs</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>April 28, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/3/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sugarloaf Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Louisiana</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairley</b>	
25C. FUNERAL DIRECTOR <b>T. Fisher, 1930 Eastern Ave.</b>		ADDRESS			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4588	
BIRTH NO. 68-4588		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>John J. De Rosa</b>		2. DATE AND HOUR OF DEATH <b>4-28-68</b> <b>15 EST</b> <b>A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>26-34</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 Church Home and Hospital</b>		C. CITY OR TOWN <b>Balto</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>5109 Darien Rd.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-13</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self employed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	9. AGE (In years last birthday) <b>54</b>
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Anthony De Rosa</b>		14. MOTHER'S MAIDEN NAME <b>Carmella Sordillo</b>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-22-4642</b>	17. INFORMANT <b>Dolores H DeRosa</b>
18. ADDRESS <b>Same</b>			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>188X</b>		<b>12 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Uremia</b>	
		(B) <b>Ureteral obstruction</b>	
		(C) <b>anaplastic carcinoma of urinary bladder</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>181.0</b>			
19A. DATE OF OPERATION <b>4-24-68</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ureteral obstruction</b>	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-13</b> 19 <b>68</b> to <b>4-28</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-28</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Ricardo M. Tusa</b>		23B. DATE SIGNED <b>4-28-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICARDO M. TUSA</b>		23D. ADDRESS <b>Church Home &amp; Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/1/68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>GARDONS OF FAITH Most Holy Redeemer</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Tusa</b>	
25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc</b>		ADDRESS <b>Baltimore, Maryland</b>	

De Rose  
M.D.

Church Home and Hospital  
2109 Danen Rd.  
6-2413 23

Self employed  
Anthony De Rose  
Carmel 2nd Mo  
Mass.

Vertical obstructive  
amphibole carcinoma of lung

Vertical obstructive

4-22 23 4-13 23

RICHARD M. TUNSON  
James H. Tunson H.D.

Church Home & Hospital

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68-4589</span>	
BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>PETER J. RAZMUS</b>		
2. DATE AND HOUR OF DEATH <b>4/29/68</b> <span style="float: right;"><b>415 P M.</b></span>			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			5. FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hosp.</b>		
C. CITY OR TOWN <b>BALTIMORE</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>4709 ELSRODE AVE.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-26-12</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Elect. Co.</b>		
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>JOSEPH RAZMUS</b>			14. MOTHER'S MAIDEN NAME <b>JULIA BOWK</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>218-05-3240</b>		17. INFORMANT <b>Mrs. Coffa N. Razmus</b>
					ADDRESS <b>(Same)</b>
18. <b>427.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>MASSIVE BRONCHOPNEUMONIA</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Massive bronchopneumonia</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>433.1 II</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3</b>		
21A. DATE OF OPERATION <b>34/29/68</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>A-V DISSOCIATION</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>YES</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>4/29</b> 19 <b>68</b> to <b>4/29</b> 19 <b>68</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>4/29</b> 19 <b>68</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>W. H. C. [Signature]</b>				23B. DATE SIGNED <b>4/29/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Union Memorial Hospital</b>				23D. ADDRESS <b>Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/3/68.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Ba lto. Md. 21214</b>	



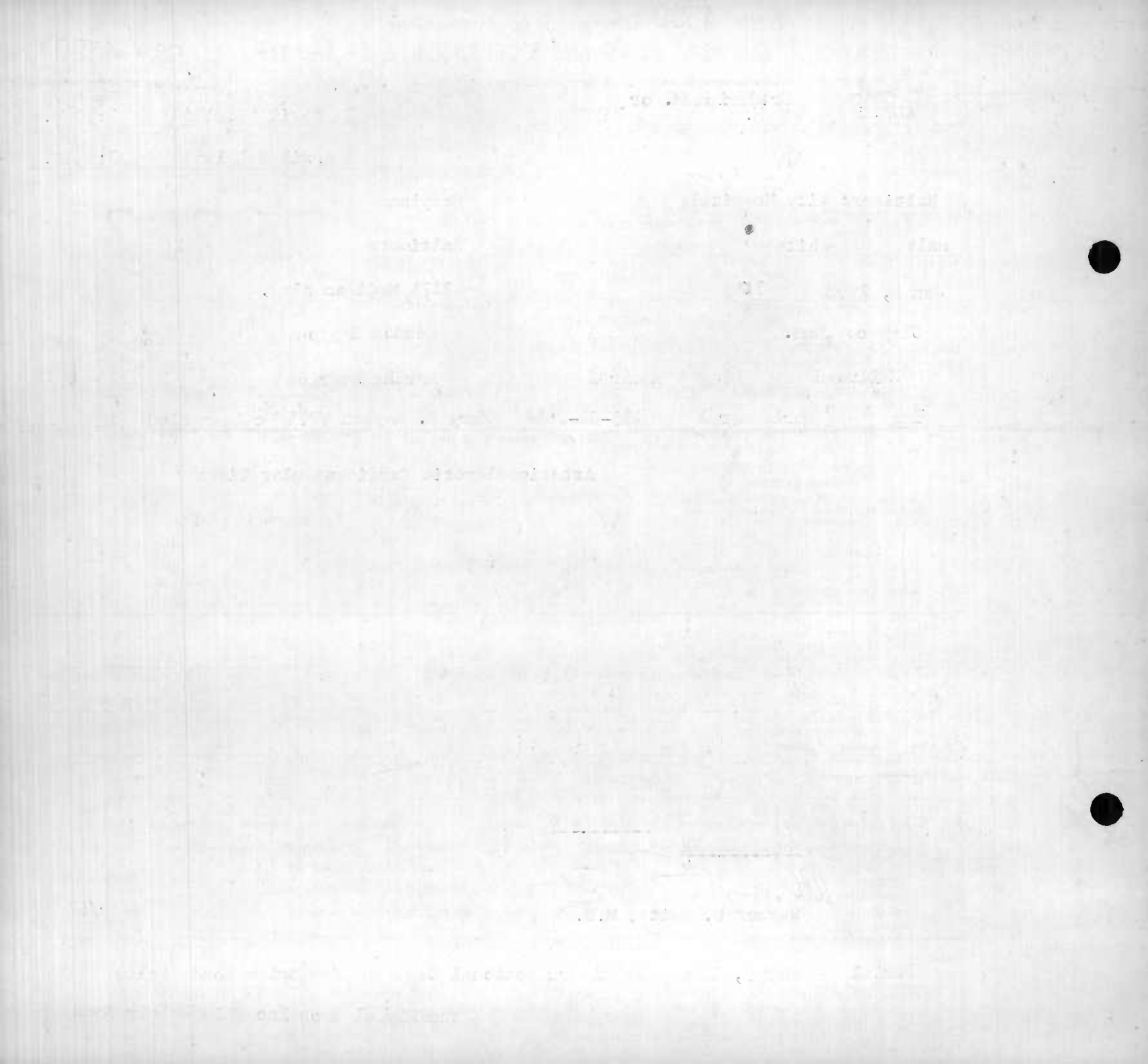


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-- 4590

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ALFRED M. RAYBON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 29, 1968</b> Hour <b>7:30 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 29, 1968 7:30 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Jan 8, 1898</b>		10. AGE (In years last birthday) <b>70</b>	
11. BIRTHPLACE (State or foreign country) <b>Clay co Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, near unknown) (If yes, give war or dates of service) <b>Yes World War I</b>		17. SOCIAL SECURITY NO. <b>213-01-0810</b>	
18. INFORMANT <b>Mary B. Raybon</b>		ADDRESS <b>7171 McClean Blvd</b>	
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>6</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>No</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>4/30/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 3, 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick Road Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>	
25C. FUNERAL DIRECTOR <b>The Dippel Bros Inc</b>		ADDRESS <b>7110 Belair Road</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

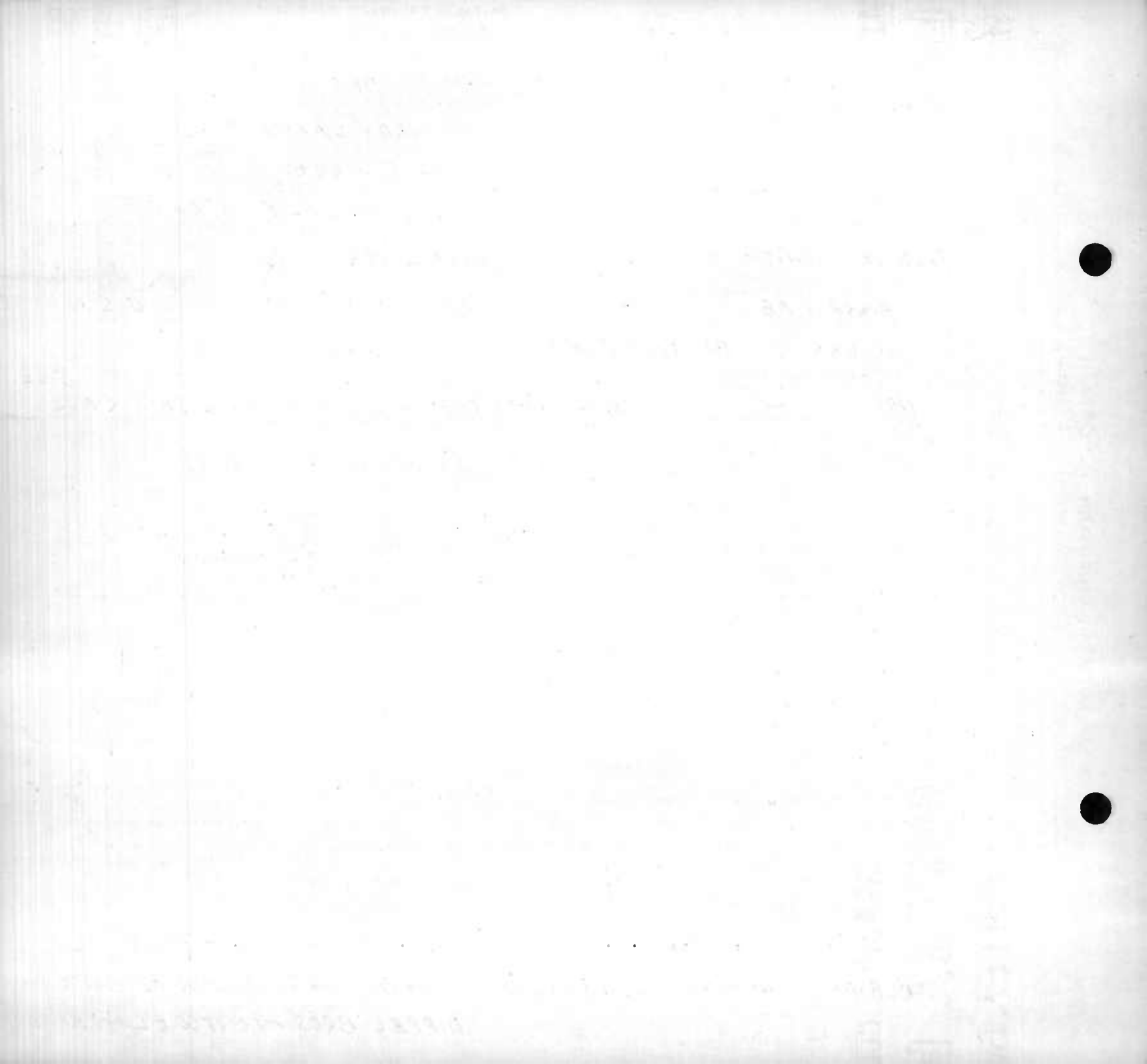
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-4591</u>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type in Print) <u>BARBARA GERTRUDE WATSIK</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>8 APRIL 30, 1968</u> <u>8<sup>10</sup> P</u> M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>MONTEBELLO STATE HOSPITAL</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>27-05</u> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>4105 Northern Parkway</u> <u>21206</u>		
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6/15/86</u> <b>9. AGE</b> (In years lost birthday) <u>81</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>John Tocher Mann</u> <u>James F. WATSIK</u>		
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Schenberger</u>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>			<b>17. INFORMANT</b> <u>HOSPITAL FACE SHEET</u> <b>ADDRESS</b>	
<b>18. CAUSE OF DEATH</b>				
<b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <u>350 X</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>NO</u>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that</b> <del>my</del> (this hospital) attended the deceased from <u>FEB 24</u> 19 <u>65</u> to <u>PRESENT 4/30 19 68</u> , that <del>we</del> (we) last saw the deceased alive on <u>4/30</u> 19 <u>68</u> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (we) (did not) view the body after death.				
<b>23A. SIGNATURE</b> <u>J. M. Coyne, M.D.</u>			<b>23B. DATE SIGNED</b> <u>4/30/68</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>J. M. COYNE, M.D.</u>			<b>23D. ADDRESS</b> <u>MONTEBELLO STATE HOSPITAL</u>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>5-3-68</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Holy Redeemer Cem</u>
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Belair Rd Balto. 6 Md.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>MAY 1 1968</u>		
<b>25B. NAME OF REGISTRAR</b> <u>R. E. Feltner</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Hippel Bros Inc 2110 Belair Rd 6</u>		

Frederick von D.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 4592
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARGARET M. GOSSMAN		APR 30 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  10 S CASTLE STREET			A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 10 S CASTLE STREET		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 4 1881	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DNK BRINKMEYER.			14. MOTHER'S MAIDEN NAME UNK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO -		16. SOCIAL SECURITY NO. 215-05-1494A		17. INFORMANT FREDERICK GOSSMAN 336 S TAYLOR AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral accident (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease (C) Arteriosclerosis -		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/21/57 to 19_____, that (I) (we) last saw the deceased alive on 4/29/68 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis Vogel, Jr., M.D.				23B. DATE SIGNED 5/1/68	
23C. PHYSICIAN'S NAME (Type) Louis Vogel, Jr., M.D.				23D. ADDRESS 2601 E. Monument St. - 21205	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE MAY-3-68		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEMETERY	
24D. LOCATION 4430 BELAIR RD BALTO MD		24E. DATE REC'D BY HEALTH DEPT. MAY 1 1968			
25A. NAME OF REGISTRAR Robert E. Farley		25B. FUNERAL DIRECTOR DIPPEL BROS INC 1800 E LOMBARD ST		25C. ADDRESS	





1  
5-630

68-4593 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-4593

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY HUNTER SURRETT

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

April 28, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

(DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

April 28, 1968

12:05 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Pikesville

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

June 20, 1934

10. AGE (In years  
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3454 Hooks Lane

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Hunter Surratt

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Auto Radiator Mechanic

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Anna Julia Hemilton

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

yes

1956-57

17. SOCIAL  
SECURITY NO.

216-30-1188

18. INFORMANT

Mrs. Nellie B. Surratt, Pikesville, Md.

ADDRESS

Hooks Lane

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

19.

412.4

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

432.1

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 28, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

May 1, 1968

24C. NAME OF CEMETERY or CREMATORY

Evergreen Mem. Gardens Finksburg, Md.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 1 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

H. J. Schardt

ADDRESS

Owings Mills, Md.

1961, 1962, 1963

1964, 1965, 1966

1967, 1968, 1969

1970, 1971, 1972

1973, 1974, 1975

1976, 1977, 1978

1979, 1980, 1981

X

1982, 1983, 1984

1985, 1986, 1987

1988, 1989, 1990

1991, 1992, 1993

1994, 1995, 1996

1997, 1998, 1999

2000, 2001, 2002

2003, 2004, 2005

2006, 2007, 2008

2009, 2010, 2011

2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020

2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030

2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040

WILLIAM B. BROWN

WILLIAM B. BROWN

WILLIAM B. BROWN

WILLIAM B. BROWN

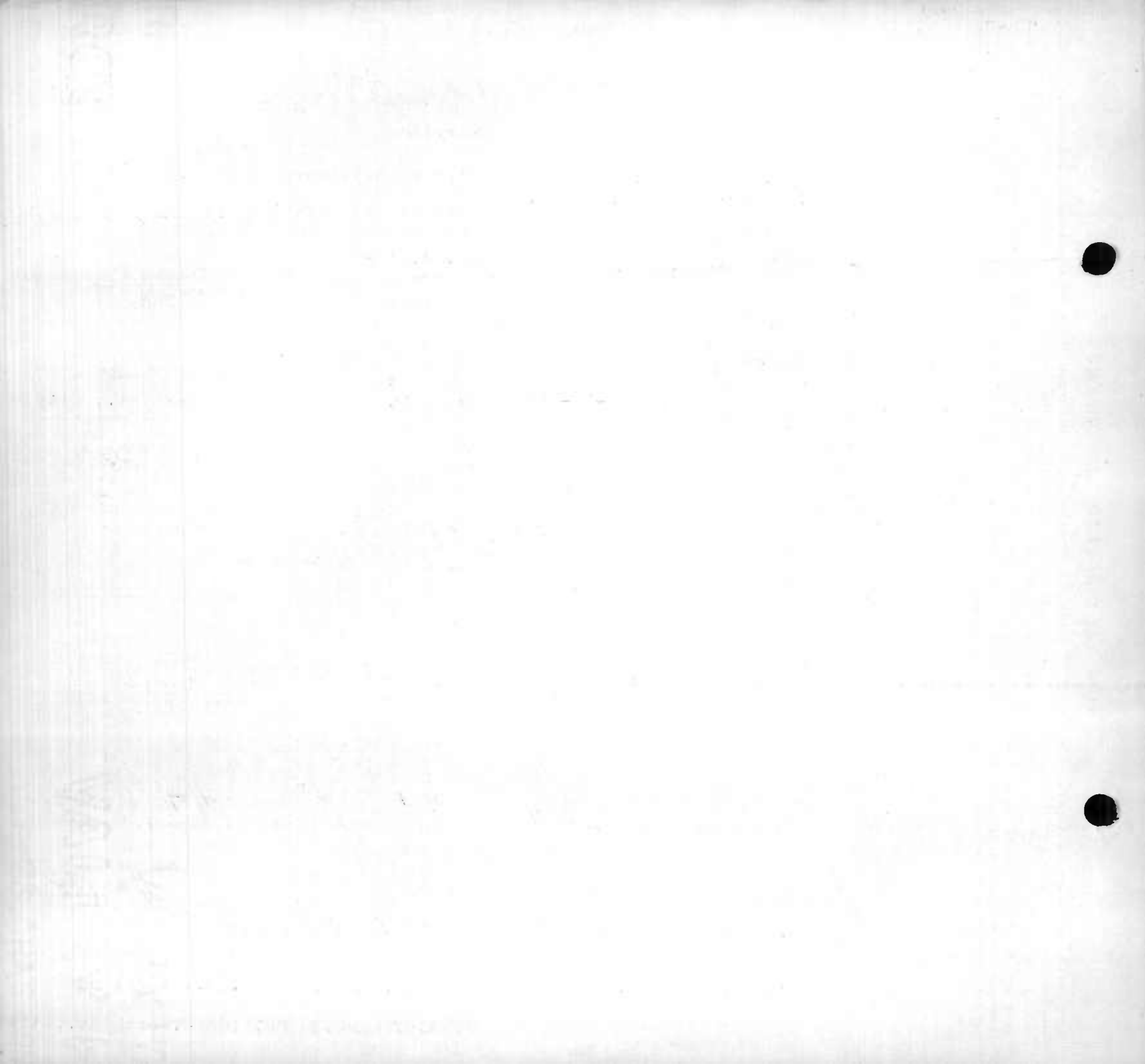
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 4594 CERTIFICATE OF DEATH

REG. NO. 68-4594

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SUSAN CATHERINE VEREKER		4/29/68 1 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland	
AT HER RESIDENCE: 1116 Forest Street, Balto.				B. COUNTY City of Baltimore	
00				C. CITY OR TOWN City of Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1116 Forest Street (Forrest) 21202	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 4, 1884	74	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NONE				Baltimore City	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Paul Keenan			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
NO			217-54-0925		
17. INFORMANT :husband			ADDRESS		
Joseph N. Vereker, 1116 Forest St., City					
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
433.0 II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/27/68 to 4/29/68, that (I) (we) last saw the deceased alive on 4/27/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph S. Blum M.D.				4/30/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOSEPH S. BLUM M.D.				1105 N. CALVERT ST.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		May 1, 1968		St. John's, Long Green, Hyde, Balto. Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 1 1968		Robert E. Farber		STEWART & MOWEN CO. 108 W. North Av., City	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department, FRANCES W. BLACKSON				REG. NO. 68-4595
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		BLACKSON, FRANCES W.		4/28/68 9:50 AM
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		MARYLAND HARFORD		
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Clerk		Penna. RailRoad		Philadelphia, Penna.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
GEORGE T. WINCHESTER (D)		EVA M. ANDERSON (D)		U.S.A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No		721-18-0498		Edward A. Blackson, Same as L. C. & E.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) perforated abdominal viscus perforation		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		pneumonia, aspiration, UTI		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
0				NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (X) (this hospital) attended the deceased from 4/25 19 68 to 4/28 19 68, that (X) (we) lost saw the deceased alive on 4/28 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
H.M. MEAGHER M.D.				4/28
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
H.M. MEAGHER		THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
Burial		5-1-68		Principio Methodist Cemetery
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
MAY 1 1968		Robert E. Tarring		Tarring Funeral Home
				Aberdeen, Md. 21001

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68-4596</b>	
B-240 68-4596		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>EDMUND L. BOSSLE Jr.</b>		2. DATE AND HOUR OF DEATH <b>4/30/68 4<sup>00</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALT.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSP</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>CAUCASIAN</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>2943 N Charles ST</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO., Md.</b>	
13. FATHER'S NAME <b>EDMUND BOSSLE SR</b>		14. MOTHER'S MAIDEN NAME <b>Nellie CAUFIELD</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-6432</b>	
17. INFORMANT <b>Mr. Francis X. Bossle</b>		ADDRESS <b>5 Seminole Avenue Balto., Md. 21228</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>1540 I Peritonitis, Acute</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>154X II Carcinoma of Colon</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>W.K.Wu</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):			
19A. DATE OF OPERATION <b>14/18/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF RECTUM</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from <b>4/3</b> 19 <b>68</b> at <b>4/30</b> 19 <b>68</b> and that (I) (we) last saw the deceased alive on <b>4/30</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Robert P. Doyle</b>		23B. DATE SIGNED <b>4/30/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT P. DOYLE MD.</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-3-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION <b>BK Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>	
25C. FUNERAL DIRECTOR <b>Witzke Funeral Directors</b>		ADDRESS <b>4101 Edmondson Avenue Balto., Md.</b>	



Examination of letter  
partially read

L. K. W.

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
I-425		68-4597		68-4597	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAM ILGENFRITZ		4-30-68 7:40A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
UNION MEMORIAL HOSP. 44			FLORIDA V-08		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			LAUDERDALE		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3200 N. E. 36th St.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-29-98	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED				MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
WILLIAM T.B. ILGENFRITZ			AMELIA CARIST MARYLAND		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES WW1		02602088		MRS. ALFRED WALL BALTIMORE	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  CARDIAC ARREST  MYOCARDIAL INFARCTION 1 day		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
NONE				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-25 1968 to 4-30 1968, that (I) (we) last saw the deceased alive on 4-29 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
MARLENE L. MARIAS				4-30-68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
MARLENE L. MARIAS					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation	5-2-68	Loudon Park Cemetery		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 1 1968		R. E. Taylor		4101 Edmondson Avenue Witzke Funeral Directors, Balto., Md. 21229	

1900

U.S. - 1900

AT RICHMOND

RETIRED

WILLIAM F. LEECH

RETIRED

RETIRED

RETIRED

U.S. - 1900

U.S. - 1900

RETIRED

RETIRED

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4598	
R-412 BIRTH NO. 68-08037 68-4598		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
ROLFES BABY BOY		APRIL 26, 1968 1:20P M.			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
40 ST. AGNES HOSPITAL				A. STATE MARYLAND B. COUNTY Baltimore 53-00	
				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1839 LOCH SHIEL RD. 21234	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/26/68	9. AGE (In years last birthday) NEW BORN	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 05
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NEW BORN				MARYLAND	
13. FATHER'S NAME JOHN P Rolfes		14. MOTHER'S MAIDEN NAME JOAN HERMAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				ST. AGNES HOSPITAL; CATON & WILKENS AVE	
18. 740 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anencephalus (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 750 X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 26 1968 to APRIL 26 1968, that (I) (we) last saw the deceased alive on APRIL 26 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Ardinger		23B. DATE SIGNED 4/29/68		23C. PHYSICIAN'S NAME (Type) JOSEPH S. ARDINGER	
23D. ADDRESS 812 Park Ave Baltimore Md		23E. DATE REC'D BY HEALTH DEPT. MAY 2 1968		23F. NAME OF REGISTRAR Robert E. Johnson	
23G. DATE OF REMOVAL (Specify) 4/30/68		23H. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23I. LOCATION (City, town, or county) Balto (State) Md	
23J. DATE REC'D BY HEALTH DEPT. MAY 2 1968		23K. NAME OF REGISTRAR Robert E. Johnson		23L. FUNERAL DIRECTOR Charles F. E. ...	

1:10

APRIL 1, 1952

1:10

1:10

CHARTER

WILLIAM

1952 HIGH SCHOOL SENIOR

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

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G-610		68-4599		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4599	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>IDELLA Groff</i>				4/27/68 6:30 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> 4940 Eastern Ave. Baltimore, Maryland # 21224				A. STATE <b>Philadelphia, Pennsylvania</b> V-35			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Philadelphia</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>				6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12-31-92</b>				9. AGE (In years last birthday) <b>75</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Amos</b>			
14. MOTHER'S MAIDEN NAME <b>Rachel Rupp</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>167-12-8796-A</b>				17. INFORMANT <b>BCH: Records 4940 Eastern Ave. Baltimore, Md.</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute myocardial infarction 3 days.</i> (B) <i>HAZARD</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/24</b> 19 <b>68</b> to <b>4/27</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/27/</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Leonard Lippman, MD</i>				23B. DATE SIGNED <b>4/27/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Leonard Lippman, MD.</b>	
23D. ADDRESS <b>Baltimore City Hospitals</b> 4940 Eastern Ave. Baltimore, Maryland #21224				24A. BURIAL CREMATION, REMOVAL (Specify)			
24B. DATE <b>April 29/68</b>				24C. NAME OF CEMETERY or CREMATORY <b>MT Beikel Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Columbia Penna</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>				25B. NAME OF REGISTRAR <i>Robert E. Feltner</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Ullrich Funeral Home 4210 Belair</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
G-600 68-4600 CERTIFICATE OF DEATH					REG. NO. 68-4506				
BIRTH NO.					68-4600				
1. NAME OF DECEASED (Type or Print) GAUER, MR. LOUIS. R.					2. DATE AND HOUR OF DEATH 4-29-68 6.30 p.m.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 35 CH & H.					A. STATE Md. -				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					B. COUNTY				
C. CITY OR TOWN BALTO.					D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER 4415 KAVON AVE. (06).									
5. SEX M.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-1-08	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Md Bank.			10B. KIND OF BUSINESS OR INDUSTRY -			11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? Md.
13. FATHER'S NAME CHARLES GAUER.					14. MOTHER'S MAIDEN NAME EMMA BLUM.				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -			16. SOCIAL SECURITY NO. 217-40-5116		17. INFORMANT MARY GAUER				ADDRESS 4415 KAVON AVE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4/23/1 CONGESTIVE HEART FAILURE.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MON.				
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) A SHD. DUE TO, OR AS A CONSEQUENCE OF:				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 20.0 II					(C) -				
19A. DATE OF OPERATION NONE.			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) -		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) -			21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -				
22. I certify that (I) (this hospital) attended the deceased from 4-27-68 to 4-29-68, that (I) (we) last saw the deceased alive on 4-29-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Nenita L. Suarez, M.D.					23B. DATE SIGNED 4-29-68.			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) NENITA L. SUAREZ, M.D.					23D. ADDRESS Church Home & Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 5/3/68		24C. NAME OF CEMETERY OR CREMATORY WOODLARK PARK			24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. MAY 2 1968			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR ADDRESS Fuller Funeral Home 1210 BELAIR			

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CHARLES GAVEL

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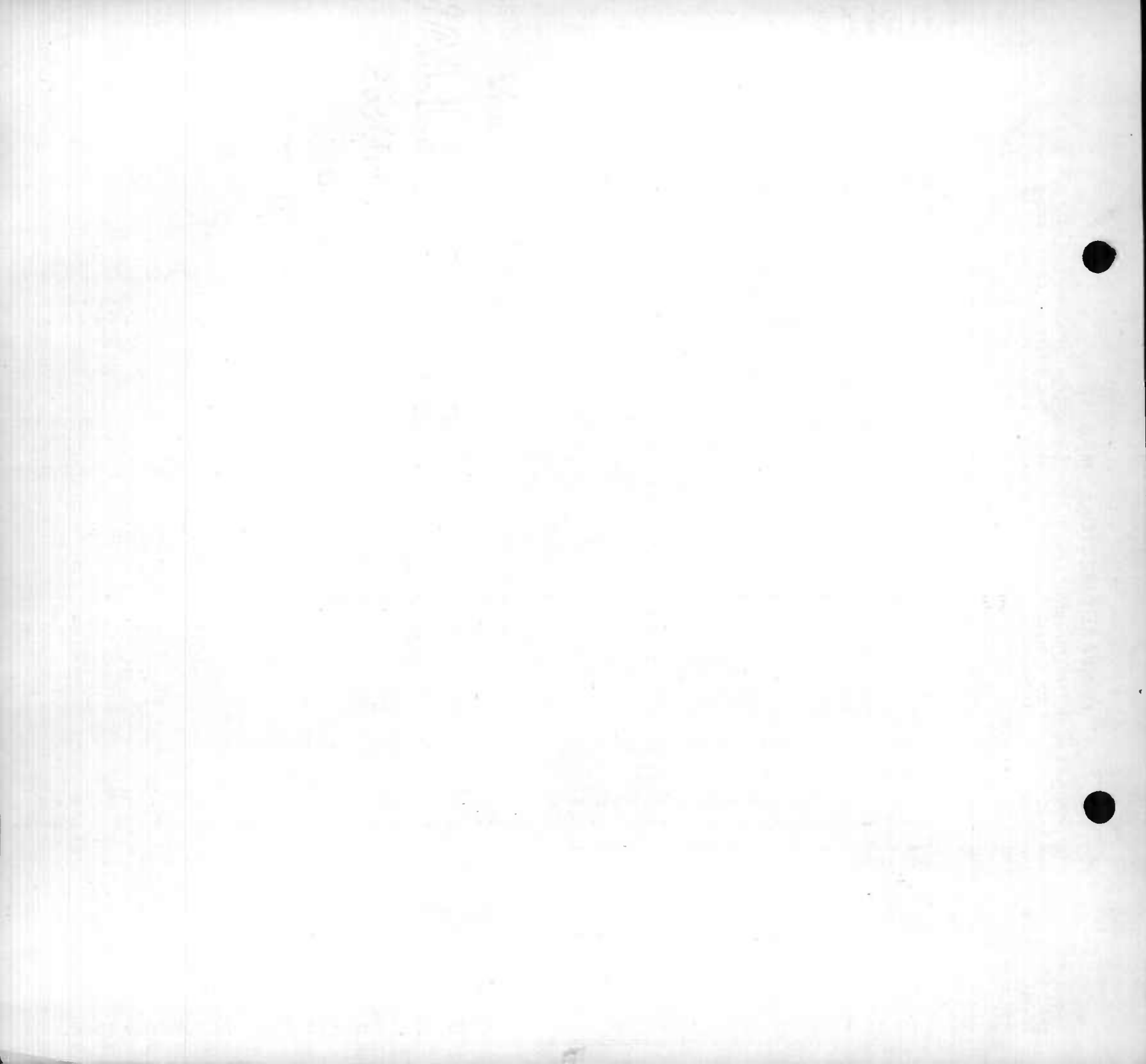
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 4601</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>5-690</b></span> <span><b>68- 4601</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>ADA V. SORRELL</b>		<b>April 29, 1968</b> <b>2:15 P.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <b>House in Pines, Belair Road,</b>			A. STATE <b>Maryland.</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>4228 Seidel Ave.</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/26/83</b>	
9. AGE (In years last birthday) <b>84</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Greswold</b>			14. MOTHER'S MAIDEN NAME <b>Tripplett</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Irene Mays, 4228 Seidel Ave.</b>	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinomatosis</b> (B) <b>Duct cell Carcinoma Int. Breast</b> (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several months</b> <b>1 yr.</b>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>170X II</b> <b>Arteriosclerotic Heart Disease, Chronic Brain Syndrome</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>June 14</b> 19 <b>63</b> to <b>April 29</b> 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>April 26</b> 19 <b>68</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <b>Albert B. Bradley</b>				23B. DATE SIGNED <b>5/1/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Albert B. Bradley, M.D.</b>				23D. ADDRESS <b>4900 Belair Road,</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/2/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
24G. FUNERAL DIRECTOR <b>Ullrich Funeral Home</b>		24H. ADDRESS <b>4210 Belair Road.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68-4602</span>	
<div style="display: flex; justify-content: space-between;"> <span>5-500</span> <span>68-4602</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Joseph Carlton Schaum</u>		2. DATE AND HOUR OF DEATH <u>4/27/68</u> <u>6:45</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>21002</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>1232 N. Calvert</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/9/08</u>	9. AGE (In years lost birthday) <u>59</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>?</u>		<u>?</u>	<u>Maryland</u>		<u>USA</u>
13. FATHER'S NAME <u>Schaum</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u>218-03-7233</u>	17. INFORMANT <u>Hospital Chart</u>		ADDRESS
18. <u>3-17-X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiopulmonary Arrest</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertension</u> (B) <u>Pulmonary Interstitial Fibrosis</u> (C) <u>Hepatic Cirrhosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 hours deep to weeks years years</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/23 1968</u> to <u>4/27 1968</u> , that (I) (we) last saw the deceased alive on <u>4/27 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Daniel Lindenstruth M.D.</u>				23B. DATE SIGNED <u>4/27/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>DANIEL LINDENSTRUTH</u>				23D. ADDRESS <u>MARYLAND GENERAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/1/68</u>		24C. NAME of CEMETERY or CREMATORY <u>CATHEDRAL</u>	
24D. LOCATION <u>BALTIMORE, Md.</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 2 1968</u>		25B. NAME OF REGISTRAR <u>R. L. J. J.</u>		25C. FUNERAL DIRECTOR <u>H.W. MEARS &amp; SON 805 N. CALVERT ST</u>	

Handwritten notes at the top left, including "1932" and "1933".

Handwritten notes in the middle left, including "10/10/38" and "22".

Handwritten notes in the center, including "1933" and "1934".

Handwritten notes at the bottom center, including "1935" and "1936".

Handwritten notes at the bottom left, including "1937" and "1938".

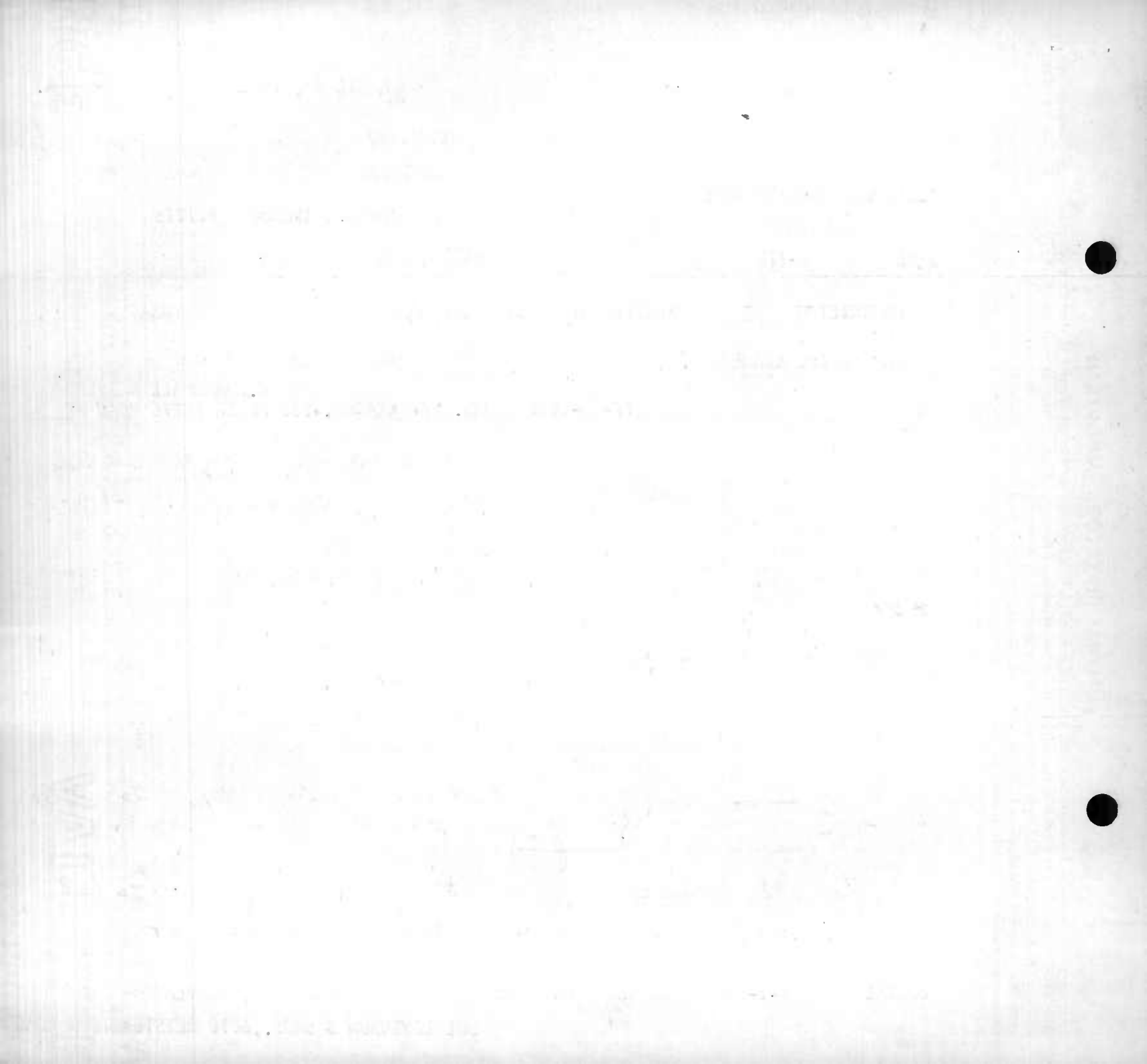
Handwritten signature or name at the bottom right.

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">68-4603</span>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">SAMUEL KRAMER</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">APRIL 30, 1968</span> <span style="float: right;">2 A.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">BELVEDERE NURSING HOME</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTIMORE</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">5727 JONQUIL AVENUE #21215</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">MALE</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">WHITE</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;"><del>XXXXXX</del></span>	<b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">68</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">PROPRIETOR</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">SERVICE STATION</span>		
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">LITHUANIA</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">SAMUEL LEE KRAMER</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">MARY ?</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">217-32-8082</span>		
<b>17. INFORMANT</b> <span style="font-size: 1.2em;">MRS. FAY KRAMER</span>		<b>ADDRESS</b> <span style="font-size: 1.2em;">c/o MR. MARSHALL KRAMER 4733 BELLE FORTE ROAD #8</span>		
<b>18. I</b> <b>CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTÉCEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Cerebral Hemorrhage</span> <span style="font-size: 1.2em;">Coronary Thrombosis</span> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <span style="font-size: 1.2em;">General &amp; cerebral sclerosis</span> <b>(C)</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">14 hrs.</span> <span style="font-size: 1.2em;">4 mos.</span> <span style="font-size: 1.2em;">4 yrs.</span>
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <span style="font-size: 1.2em;">B31X II</span>				
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Approx.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Oct. 17</span> 19 <span style="font-size: 1.2em;">46</span> to <span style="font-size: 1.2em;">Apr. 30</span> 19 <span style="font-size: 1.2em;">68</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Apr. 29</span> 19 <span style="font-size: 1.2em;">68</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Louis E. Wice</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">4/30/68</span>		<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Louis E. Wice M.D.</span>
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">BURIAL</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">5-1-68</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">HEBREW YOUNG MENS</span>
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAY 2 1968</span>		
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>		

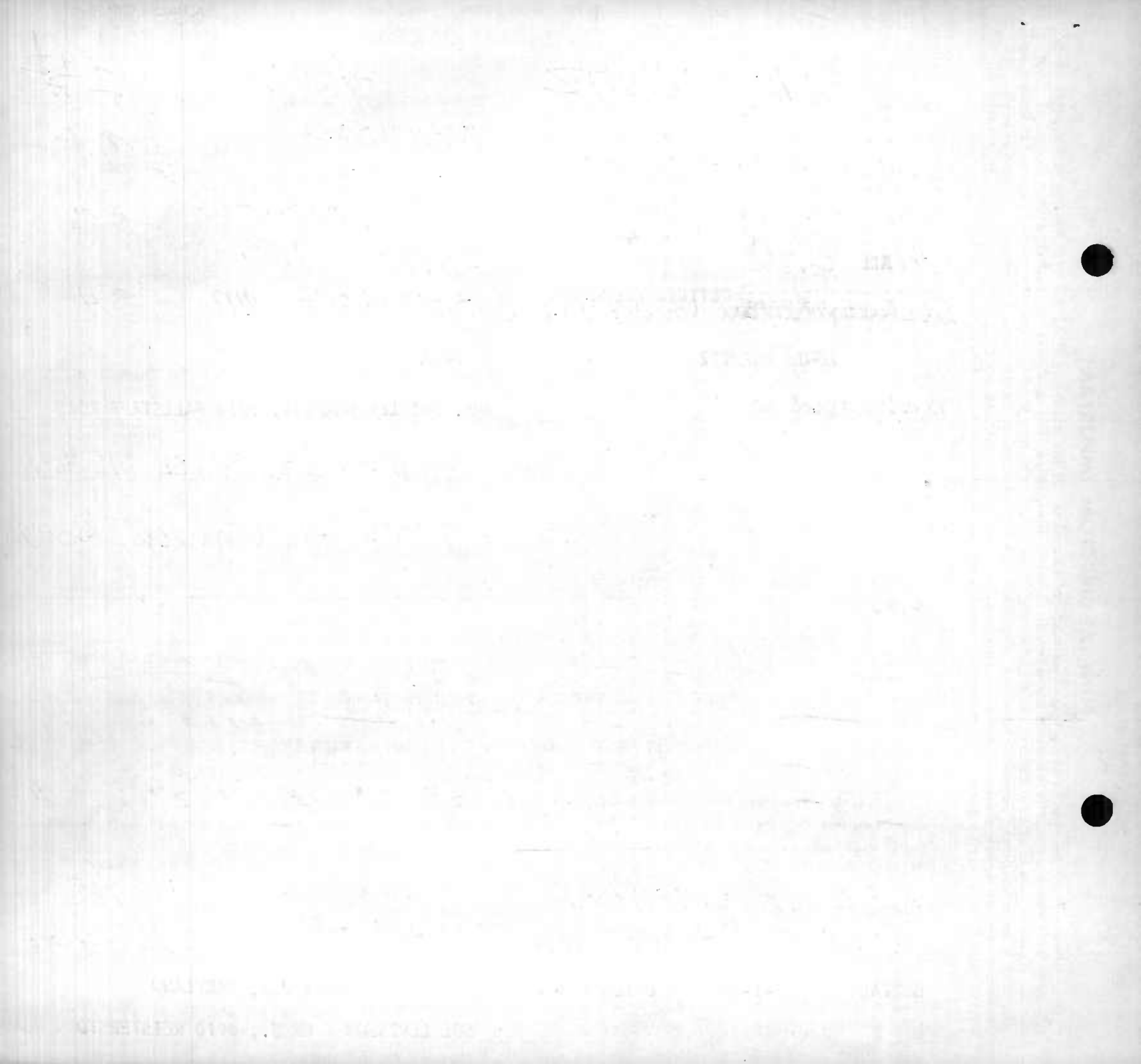




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

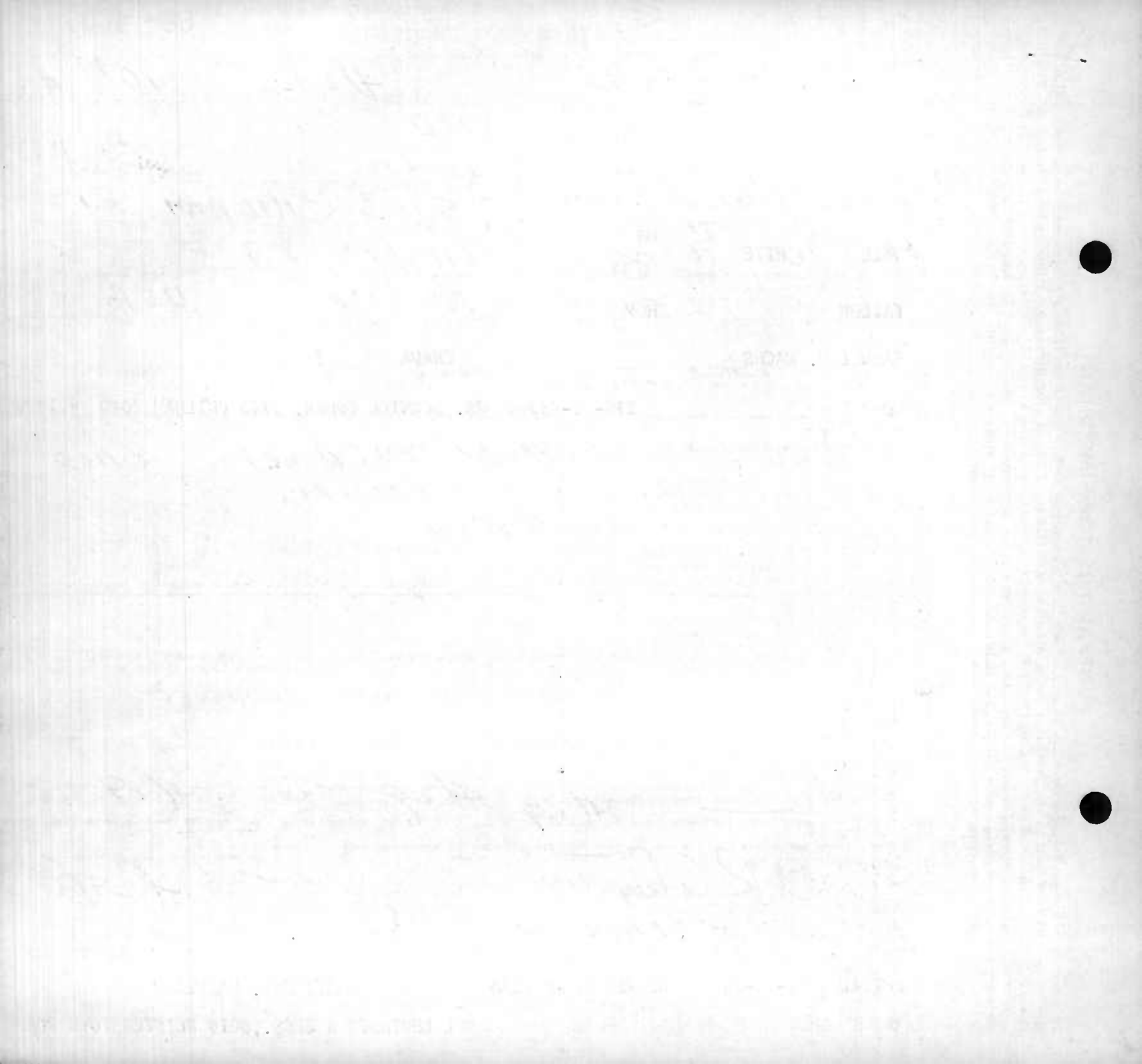
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4604</b>
H-632 68-4604 CERTIFICATE OF DEATH				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PHILIP HURWITZ</b>		
2. DATE AND HOUR OF DEATH <b>4/29/68 12:45</b> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE INC</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>MALE</b>		6. RACE <b>CAU</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>2/1/95</b>		9. AGE (In years lost birthday) <b>73</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED EXECUTIVE</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>LOUIS HURWITZ</b>		14. MOTHER'S MAIDEN NAME <b>DORA ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. SHIRLEY HURWITZ, 3218 FALLSTAFF ROAD</b>
18. <b>4/20/68</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIOGENIC SHOCK 10 Hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>ACUTE MYOCARDIAL INFARCTION 28 Hours</b> DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) .....		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <b>4/28</b> 19 <b>68</b> to <b>4/29</b> 19 <b>68</b> , that (1) (we) lost saw the deceased alive on <b>4/29</b> 19 <b>68</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Ronald Patch M.D.</b>		23B. DATE SIGNED <b>4/29/68</b>		23C. PHYSICIAN'S NAME (Type) <b>RONALD PATCH M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-1-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>



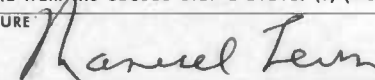
**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 4605</b>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>HARRY WACHS</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>4/29-68 10<sup>30</sup> A</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Hebrew Home of Balto</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY _____  <b>C. CITY OR TOWN</b> <b>BALTO.</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  <b>E. STREET AND NUMBER</b> <b>5703 CHILHAM R</b>		
<b>5. SEX</b> <b>MALE</b>	<b>6. RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2/19/85</b>	<b>9. AGE</b> (In years last birthday) <b>83</b> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>SHOP</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>RUSSIA</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA.</b>		<b>13. FATHER'S NAME</b> <b>SAMUEL M. WACHS</b>		
<b>14. MOTHER'S MAIDEN NAME</b> <b>CHAVA ?</b>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
<b>16. SOCIAL SECURITY NO.</b> <b>216-22-4530A</b>		<b>17. INFORMANT</b> <b>MRS. BERNICE COHEN, 5703 CHILHAM ROAD #21209</b>		
<b>18. CAUSE OF DEATH</b> <b>CHRON. CONG. HEART FAILURE</b> <b>ASCVD.</b> <b>8 MOS</b>				
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>422.1 II</b>				
<b>19A. DATE OF OPERATION</b> <b>4/28</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY? (Yes or No)</b> <b>NO</b>		
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from 4/28 19 68 to 4/29 19 68, that (I) (we) last saw the deceased alive on 4/29 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <b>Edward R. Cohen MD</b>		<b>23B. DATE SIGNED</b> <b>4/29/68</b>		
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>EDWARD R. COHEN, MD</b>		<b>23D. ADDRESS</b> <b>Hebrew Home</b>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>24B. DATE</b> <b>4-30-68</b>		
<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>HEBREW YOUNG MENS</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 2 1968</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, MD</b>		
<b>25C. FUNERAL DIRECTOR</b> <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		<b>ADDRESS</b>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4606</b>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="float: right;"><b>JACOB BOGRAD</b></span>		<b>CERTIFICATE OF DEATH</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>SINAI HOSPITAL</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>APRIL 29, 1968</b>   <b>2</b> A.M.  <b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto. Co.</b> <b>5. CITY OR TOWN</b> <b>BALTIMORE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>3314 ESSEX ROAD #21207</b>		
<b>5. SEX</b> <b>MALE</b>	<b>6. RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9-22-1894</b>	<b>9. AGE</b> (In years lost birthday) <b>73</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>RETAIL</b>		
<b>11. BIRTHPLACE</b> (State or foreign country) <b>RUSSIA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>NATHAN BOGRAD</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>RUTH ?</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>218-32-2492</b>		
<b>17. INFORMANT</b> <b>MRS. ESTHER SAPPERSTEIN</b>		<b>ADDRESS</b> <b>3314 ESSEX ROAD, BALTIMORE 21207</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>410.9 I</b> <b>Acute myocardial Infarction</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b>		
<b>ANTECEDENT CAUSES</b>  <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b>		<b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>arteriosclerotic Heart Disease</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(C) _____</b>		
<b>19. DATE OF OPERATION</b> <b>420.1 II</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>Empyema obliterative</b>		
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>No</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from July 1966 to April 29 1968, that (I) (we) last saw the deceased alive on April 29 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> 		<b>23B. DATE SIGNED</b> <b>4/29/68</b>		<b>23C. PHYSICIAN'S NAME</b> (Type) <b>MANUEL LEVIN</b>
<b>23D. ADDRESS</b> <b>6101 PARK HEIGHTS AVENUE</b>		<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		
<b>24B. DATE</b> <b>4-30-68</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>WORKMENS CIRCLE</b>		
<b>24D. LOCATION</b> (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 2 1968</b>		
<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Tarkenton</b>		<b>25C. FUNERAL DIRECTOR</b> <b>SOL LEVINSON &amp; BROS. INC.</b> <b>6010 REISTERSTOWN ROAD, BALTO. 21215</b>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-210 68-4607				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4607	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Betty Paskoff</i>		2. DATE AND HOUR OF DEATH <i>4. 29. 68</i> <i>11. 45 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>42 SINAI HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>42 SINAI HOSPITAL</i>				E. STREET AND NUMBER <i>4304 REISTERSTOWN ROAD</i>		F. CITY AND NUMBER <i>#21215</i>	
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>[REDACTED]</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>DAVID MARKMAN</i>				14. MOTHER'S MAIDEN NAME <i>BETH ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>[REDACTED]</i>		17. INFORMANT <i>MR. AARON PASKOFF, 6210 PARK HEIGHTS AVE.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Probable Pulmonary</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Symbolism</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Fr left femur</i>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if only giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>E 904.0 II</i>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <i>14. 28. 68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fr left femur</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21C. WHERE DID INJURY OCCUR? <i>4304 Reisterstown Rd</i>		(If In Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <i>4-27-68</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>fell at home</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>4. 29. 1968</i> to <i>4. 29. 1968</i> , that (I) (we) lost saw the deceased alive on <i>4. 29. 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>R. Theodore</i>				23B. DATE SIGNED <i>4. 29. 68</i>		23C. PHYSICIAN'S NAME (Type) <i>ROGER THEODORE</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>				24B. DATE <i>4-30-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>BNAI ISRAEL</i>	
24D. LOCATION <i>BALTIMORE, MARYLAND</i>				24E. STREET AND NUMBER <i>4304 REISTERSTOWN ROAD</i>		24F. CITY AND NUMBER <i>#21215</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 2 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS.</i>		25D. ADDRESS <i>6010 REISTERSTOWN ROAD</i>	

1904 COLLECTION ROAD, CHINA

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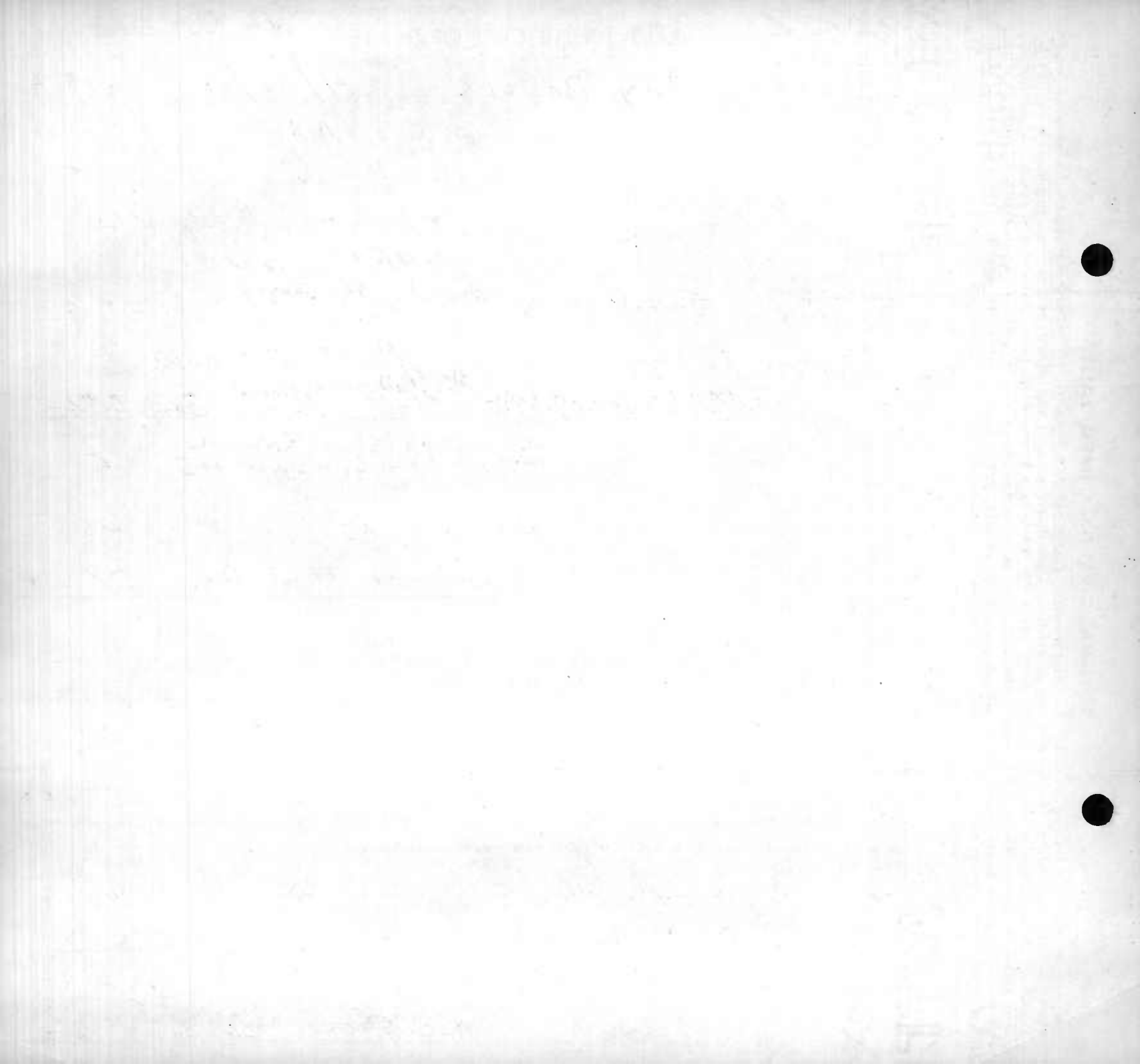
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620		68-4608		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4608	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Walter Jay Bayors</i>			
2. DATE AND HOUR OF DEATH <i>4/30/68 5:15 A.M.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>38 University</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University</i>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>AA C</i>				C. CITY OR TOWN <i>Glen Burnie</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <i>102 King George Dr.</i>							
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/11/17</i>	9. AGE (In years last birthday) <i>50</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Jos. L. Prosser Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Newark, New Jersey N.J.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Bayors</i>				14. MOTHER'S MAIDEN NAME <i>Martha Haake</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>147-09-5820</i>		17. INFORMANT <i>Mrs. Margaret C. Bayors</i>		ADDRESS <i>Chant (Wife) Same As #4</i>	
18. <i>39601</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Status post op sternal - Edwards valve prosthesis &amp; residual MI</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>MI, MS, AI</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>MI, MS, AI</i>				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Rheumatic heart Dx</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>410X II</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5</i>			
19A. DATE OF OPERATION <i>June 63</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>MI, MS, AI</i>		20A. AUTOPSY? (Yes or No) <i>No.</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>June 19 63</i> to <i>4/30 19 68</i> , that (I) (we) last saw the deceased alive on <i>4/29 19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Francis D. Drake, M.D.</i>				23B. DATE SIGNED <i>4/30/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Francis D. Drake, M.D.</i>	
23D. ADDRESS <i>University Heights</i>				24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>May 3, 1968</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>Pikesville, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 2 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Feltner</i>		25C. FUNERAL DIRECTOR <i>R. Singleton</i>		ADDRESS <i>Singleton Funeral Home Glen Burnie, Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4609</b>
<b>C-320</b> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>HENRY COATES</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>4/29/68</b> <b>7:30 P.M.</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>48 Maryland Gen. Hospital</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>MD</b> <b>B. COUNTY</b> <b>Baltimore</b> <b>53-00</b>		
<b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <b>48 Maryland Gen. Hospital</b>		<b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>5. SEX</b> <b>M</b> <b>6. RACE</b> <b>W</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>		<b>8. DATE OF BIRTH</b> <b>8/2/97</b> <b>9. AGE</b> (In years last birthday) <b>70</b>		
<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MD</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>US.</b>		
<b>13. FATHER'S NAME</b> <b>A. Wesley Coates</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Zimmerman</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>W. W. I</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214 071113</b> <b>17. INFORMANT</b> <b>Mabel L. Coates</b> <b>ADDRESS</b> <b>6 PIPER RD Box 272 Rt 4 Balto. Md. 21227</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>5-69-9 I</b>		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <b>Cardiac Arrest</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Acute Pulmonary Edema</b> <b>(B) MYOCARDIAL INFARCTION</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) G.I. haemorrhage.</b>		
<b>19. DATE OF OPERATION</b> <b>5-7-8 X</b> <b>II</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>4/28/1968</b> <b>to</b> <b>4/29/1968</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>4/29/1968</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <b>S. Swaroop</b> <b>MD</b> <b>DEGREE</b>		<b>23B. DATE SIGNED</b> <b>4/29/68</b>		
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>S. Swaroop</b> <b>MD</b> <b>DEGREE</b>		<b>23D. ADDRESS</b> <b>MD. Gen. Hospital</b>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>5/2/68</b>		
<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Landon Park Cemetery</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 2 1968</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Jackson</b>		
<b>25C. FUNERAL DIRECTOR</b> <b>1328 Sulphur</b>		<b>ADDRESS</b> <b>Ambrose Inc. Spring Road</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>51-58-31</span> <span>0-422</span> <span>68- 4610</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span>IN</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 68- 4610</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GERTRUDE OLSZEWSKI</b> <i>Gertrude Olszewski</i>		2. DATE AND HOUR OF DEATH <b>4-25-68</b>   <b>2<sup>10</sup> A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b> <b>BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>612 S. Port Street - 21224</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/18/23</b>	9. AGE (In years last birthday) <b>45</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>THOMAS SOBUL</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA BERTHA BIELAK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-18-0406</b>		17. INFORMANT RECORDS: <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue, Baltimore, Md. 21224</b>	
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Intra-ventricular - cerebral hemorrhage</b> (B) <b>Hypertensive arteriosclerotic Cardiovascular disease</b> (C) <b>Possible Bleeding Diathesis, undiagnosed</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>443X II</b>					
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-24-</b> 19 <b>68</b> to <b>4-25</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-25</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Mark Lowmiller, M.D.</i> DEGREE				23B. DATE SIGNED <b>4/25/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARK LOWMILLER</b> <i>MARK Lowmiller, M.D.</i> DEGREE		23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue, Baltimore, Md. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>4/29/68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy ROSARY CEMETERY</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>	25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b> ADDRESS <b>2525 FLEET ST.</b>			



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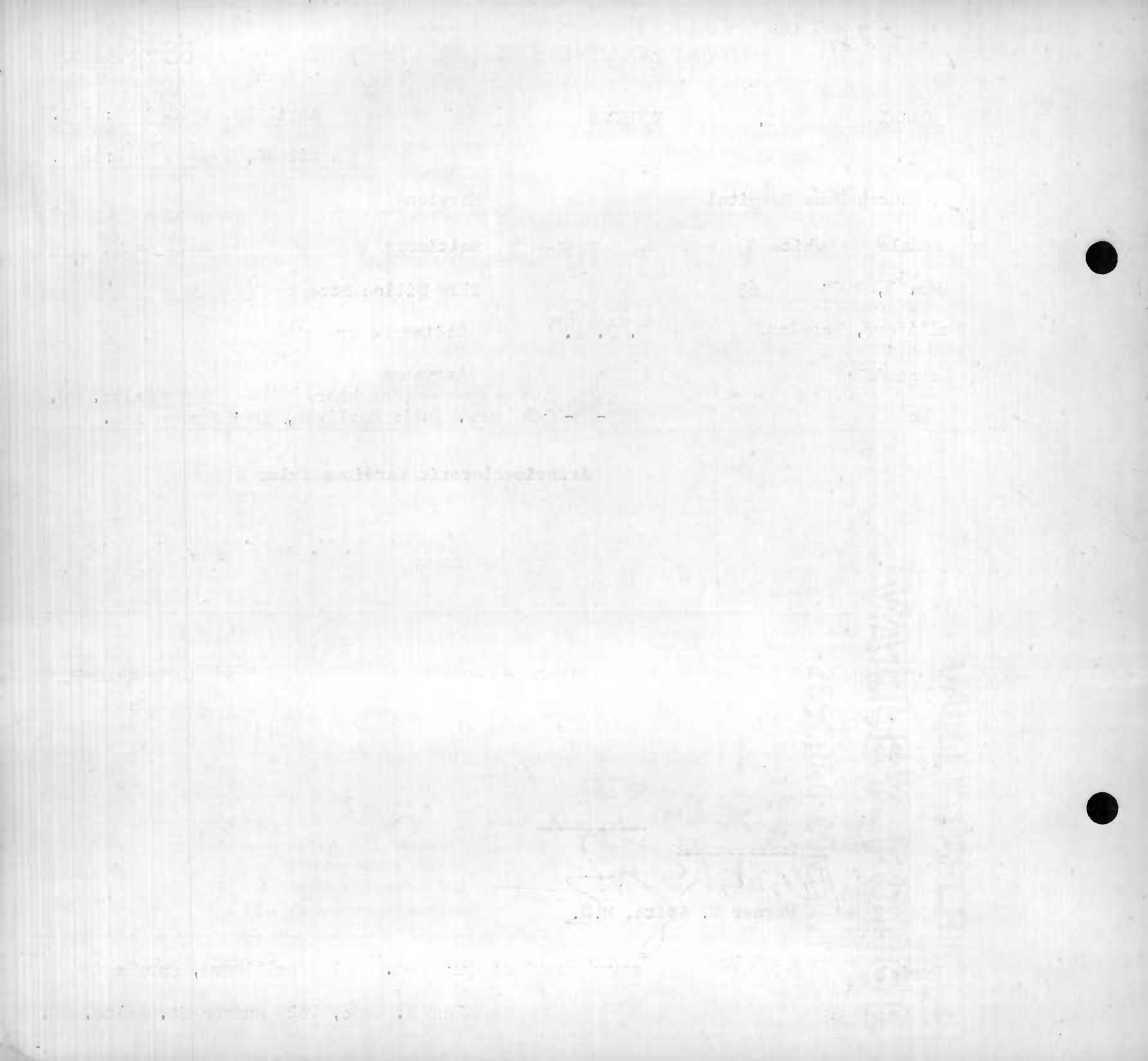
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1-526 68-4611 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 68-4611

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CARRIE R. YOUNGER</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 28, 1968</b> 3:45 P. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Church Home Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 28, 1968</b> 3:45 P. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>female</b>		7. RACE <b>white</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Dec. 3, 1904</b>		10. AGE (In years last birthday) <b>63</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		E. STREET AND NUMBER <b>2720 Dillon Street</b>	
12. CITIZEN OF <b>U. S. A.</b>		13. FATHER'S NAME <b>Walter Bober</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		15. MOTHER'S MAIDEN NAME <b>Maryanna ?</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>219-03-2364</b>		18. INFORMANT (Daughter) <b>Mrs. Julia Heyliger, 5205 Kramme Ave.</b>		ADDRESS <b>Balto. Md.</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>0</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>No</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type)  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>4/29/68</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/3/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart of Mary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>		25C. FUNERAL DIRECTOR <b>John J. Duda, 2829 Hudson St. Balto. MD.</b>		ADDRESS	



BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 68-4612

BIRTH NO.

1. NAME OF DECEASED Albert Raymond Lowman, Sr.  
(Type or Print)

ALBERT LOWMAN Sr

2. DATE OF DEATH Known ☒ Month 4 Day 30 Year 68 Hour 1:45 p.m.  
Estimated ☐

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospital D.O.A.

3. DATE PRONOUNCED DEAD Month April Day 30 Year 1968 Hour 1:45 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

6. SEX Male 7. RACE White 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH July 18 1917 10. AGE (In years last birthday) 50  
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER 108 W. Jeffrey St. 21225

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME John R. Lowman

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver

14B. KIND OF BUSINESS OR INDUSTRY Western Md. Transfer

15. MOTHER'S MAIDEN NAME Alverta Stallings

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None

17. SOCIAL SECURITY NO.

18. INFORMANT Mrs. Dorothy Lowman ADDRESS 108 W. Jeffrey Street 21225

19. 412.4  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH  
Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Ronald N. Kornblum M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.

May 1, 1968

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 5/4/68

24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park

24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. 21122

25A. DATE REC'D BY HEALTH DEPT. MAY 2 1968

25B. NAME OF REGISTRAR Robert E. Taylor

25C. FUNERAL DIRECTOR ADDRESS McCully F. H. 237 Patapsco Ave. 21225

WAITING FOR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-4613

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MILDRED PETTY</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>753 W. Baltimore St.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 28, 1968 3:00 A</b>			
6. SEX <b>Female</b>				7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH <b>Feb. 22, 1936</b>				10. AGE (In years last birthday) <b>32</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Unknown</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
15. MOTHER'S MAIDEN NAME <b>Unknown</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Miss Stella Miser</b>				ADDRESS <b>206 Jack Street 21225</b>			
19. <b>796.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH <b>Undetermined (complete autopsy and toxicological findings not sufficient to explain death).</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)			
20. DATE OF OPERATION <b>795.5</b>				21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>April 28, 1968</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/2/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, A. A. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>McCully F.H.</b>		ADDRESS <b>237 Patapsco Ave. 21225</b>	

WALTER P. HARRIS

WALTER P. HARRIS

WALTER P. HARRIS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4614</b>
BIRTH NO. <b>5-520</b>		<b>68-4614</b> <b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>George Elias Jones</b>		2. DATE AND HOUR OF DEATH <b>May 1, 1968</b> <b>6 A.</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>5905 Marluth Avenue Baltimore, Maryland</b>		A. STATE <b>Maryland</b> B. COUNTY <b>(Baltimore)</b>		
C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>5905 MARLUTH AVE.</b>				
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1891</b>	9. AGE (In years lost birthday) <b>76</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>George Andrew Jones</b>		14. MOTHER'S MAIDEN NAME <b>Frances A. Peterson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW#1</b>		16. SOCIAL SECURITY NO. <b>215-05-7110</b>		17. INFORMANT (Nephew) <b>687-6411</b> ADDRESS <b>9739 Matzon Road Baltimore, Md. 21220</b>
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic cardiovascular disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>10 years</b> (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II</b>				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>June 7 1966</b> to <b>May 1 1968</b> , that (I) (we) last saw the deceased alive on <b>April 24 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Adam G. Swiss</b>		DEGREE <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys.		23B. DATE SIGNED <b>May 1, 1968</b>
23C. PHYSICIAN'S NAME (Type) <b>ADAM G. SWISS</b>		23D. ADDRESS <b>6232 Belair Road, Baltimore, Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>May 4, 1968</b>	24C. NAME of CEMETERY or CREMATORY <b>St Ignatius Cath. Ch. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Bel Air, Harford Co., Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	25C. FUNERAL DIRECTOR <b>Joseph William Foster</b> ADDRESS <b>W. Broadway &amp; Williams St., Bel Air, Maryland 21014</b>		

[illegible]

*[Faint handwritten notes at the bottom of the page]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4615
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>WILLIAM H. HANEY</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>4/30/68 2:20 A.M.</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore City</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2805 HUNTINGDON AVE. 2805</b>		<b>5. SEX</b> <b>MALE</b> <b>6. RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>6/10/88</b> <b>9. AGE</b> (In years lost birthday) <b>79 yrs.</b> <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer</b> <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>L. Greif &amp; Son</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>AMERICA</b>		
<b>13. FATHER'S NAME</b> <b>WILLIAM HANEY (D)</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>ROSALIE GREENWALD</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>213-28-4744</b> <b>17. INFORMANT</b> <b>CARRIE E. HANEY</b> <b>ADDRESS</b> <b>SAME AS above</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction</b> (B) <b>A.S.C.V.D. ? Hypertension</b> (C)		
<b>19A. DATE OF OPERATION</b> <b>4-20-1</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>II</b>		
<b>20A. AUTOPSY? (Yes or No)</b> <b>NO</b>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from 4/29/1968 to 4/30/1968, that (I) (we) last saw the deceased alive on 4/30/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <b>DERMOT CAMPBELL M.D.</b>		<b>23B. DATE SIGNED</b> <b>4/30/68</b>		
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>DERMOT CAMPBELL M.D.</b>		<b>23D. ADDRESS</b> <b>THE UNION MEMORIAL HOSPITAL</b>		
<b>24A. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>5-3-1968</b>		
<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Lorraine Park</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Woodlawn Md.</b>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 2 1968</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Farber</b>		
<b>25C. FUNERAL DIRECTOR</b> <b>G. Howard Strong</b>		<b>ADDRESS</b> <b>3207 W. North Ave.,</b>		

4/20/82  
Baltimore  
Harrison Ave 2802  
photos 20 up.

John Thomas Wright  
Baltimore White

4/20/82  
Baltimore  
Baltimore Greenwald  
213 Greenwald Green E 1st St

William Harvey D  
Baltimore

4/20/82  
A 21. V. D. 7. 11/1/82

no

4/20/82

4/20/82  
Dennis Campbell MS  
Dennis Campbell MS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-165		68-4616		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4616	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) <b>FREDERICK T. HEBRON</b>				2. DATE AND HOUR OF DEATH <b>4.30.68</b> <b>#</b> <b>150</b> <b>AM.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>919 N. CASTLE ST.</b>			
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3.15.01</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Steelworker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FREDERICK HEBRON</b>				14. MOTHER'S MAIDEN NAME <b>MATILDA KIMBELL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-1253</b>		17. INFORMANT <b>Ethel Hebron</b>		ADDRESS <b>919 Castle St</b>	
18. <b>162.1</b> <b>I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>EXTREME CACHEXIA</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>CARCINOMA of LUNGS, C</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>METASTASES (SUPRACLAV. NODE,</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>WKS.</b> <b>MONTHS.</b> <b>MONTHS.</b>	
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ADRENALS, KIDNEY</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>(H)</del> (this hospital) attended the deceased from <b>4.27.1968</b> to <b>4.30.1968</b> , that <del>(H)</del> (we) last saw the deceased alive on <b>4.30.1968</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(H)</del> (We) (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>Bruce W. Pfeffer, M.D.</b> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4.30.68</b>	
23C. PHYSICIAN'S NAME (Type) <b>BRUCE W. PFEFFER M.D.</b> DEGREE				23D. ADDRESS <b>Mercy Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>May 2 1968</b>		<b>St. Calvary Cem</b>		<b>A.A. County Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Thomas J. Jackson</b>		ADDRESS <b>1137 N. Channing</b>	

1/25/20  
M. H.

2.5.01

Excise cases

(Cases of late)

Revenue (Revenue)

Revenue (Revenue)

Revenue

Revenue

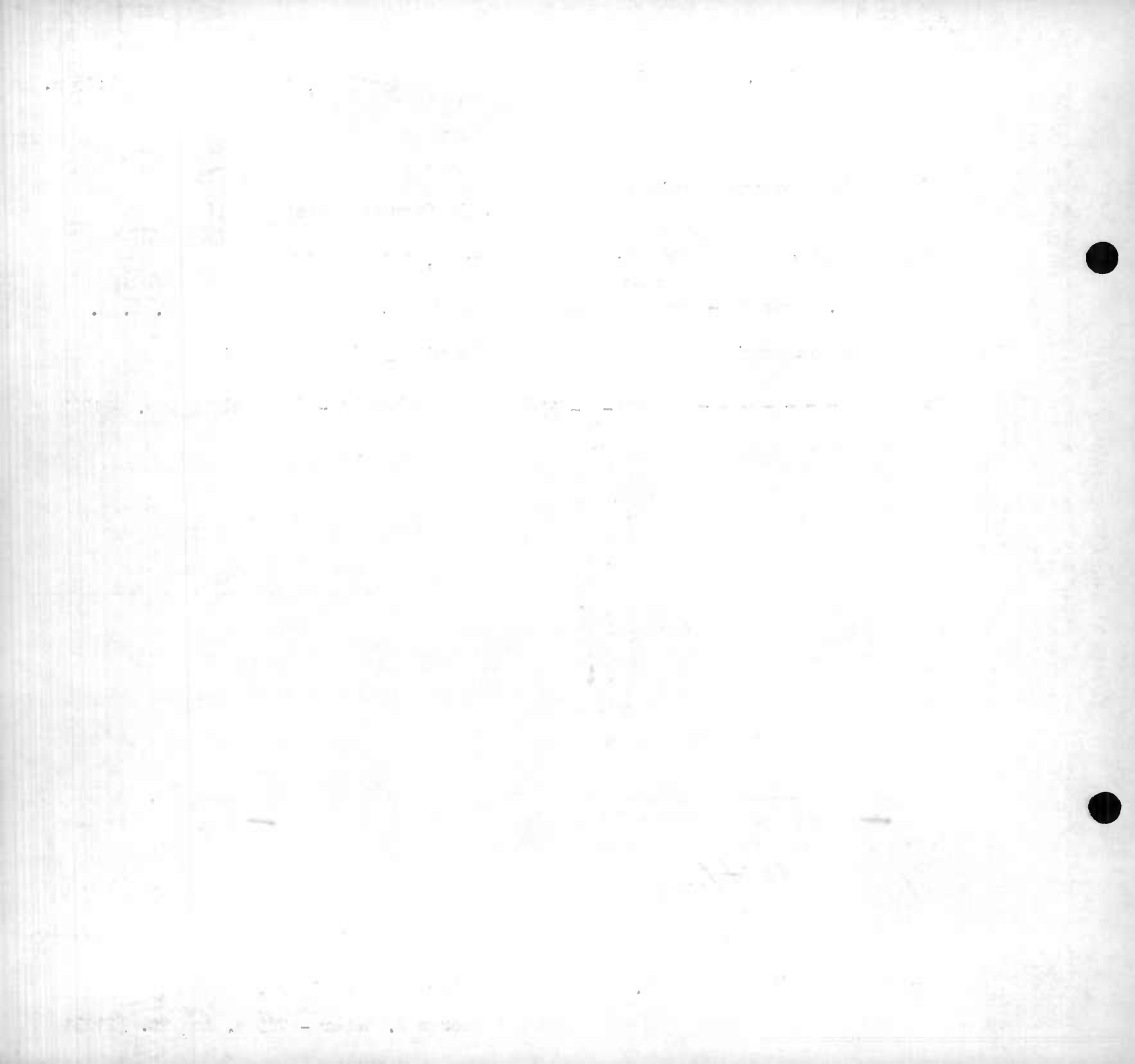
Revenue

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>1-K-322</b>		BALTIMORE CITY HEALTH DEPARTMENT		68-4617	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No. _____	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Casimir A. Kotkowski		April 30, 1968		7:15 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
DOA Maryland General Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		435 Gusryan Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	White	Single	Mar 24, 1919	49	U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Motion Pict. Inspector- Censor Bureau		Maryland State		Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Felix Kotkowski		Hedwig (Ida) Judzikowski			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-09-5336		James Kotkowski - 6720 Duluth Ave. #21222	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CORONARY OCCLUSION DUE TO Arteriosclerotic Heart Disease DUE TO with hypertension		10 minutes 4 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		4044			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Feb. 19 63 to Mar 24, 1967, that (I) lost saw the deceased alive on Mar 24, 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
R. H. Spitzberg				May 1, 68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
R. H. SPITZBERG				1515 WASHINGTON BLVD. Balto MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5/4/68		St. Stanislaus Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 2 1968		Robert E. Taylor		George A. Weber - 705 S. Ann St. #21231	





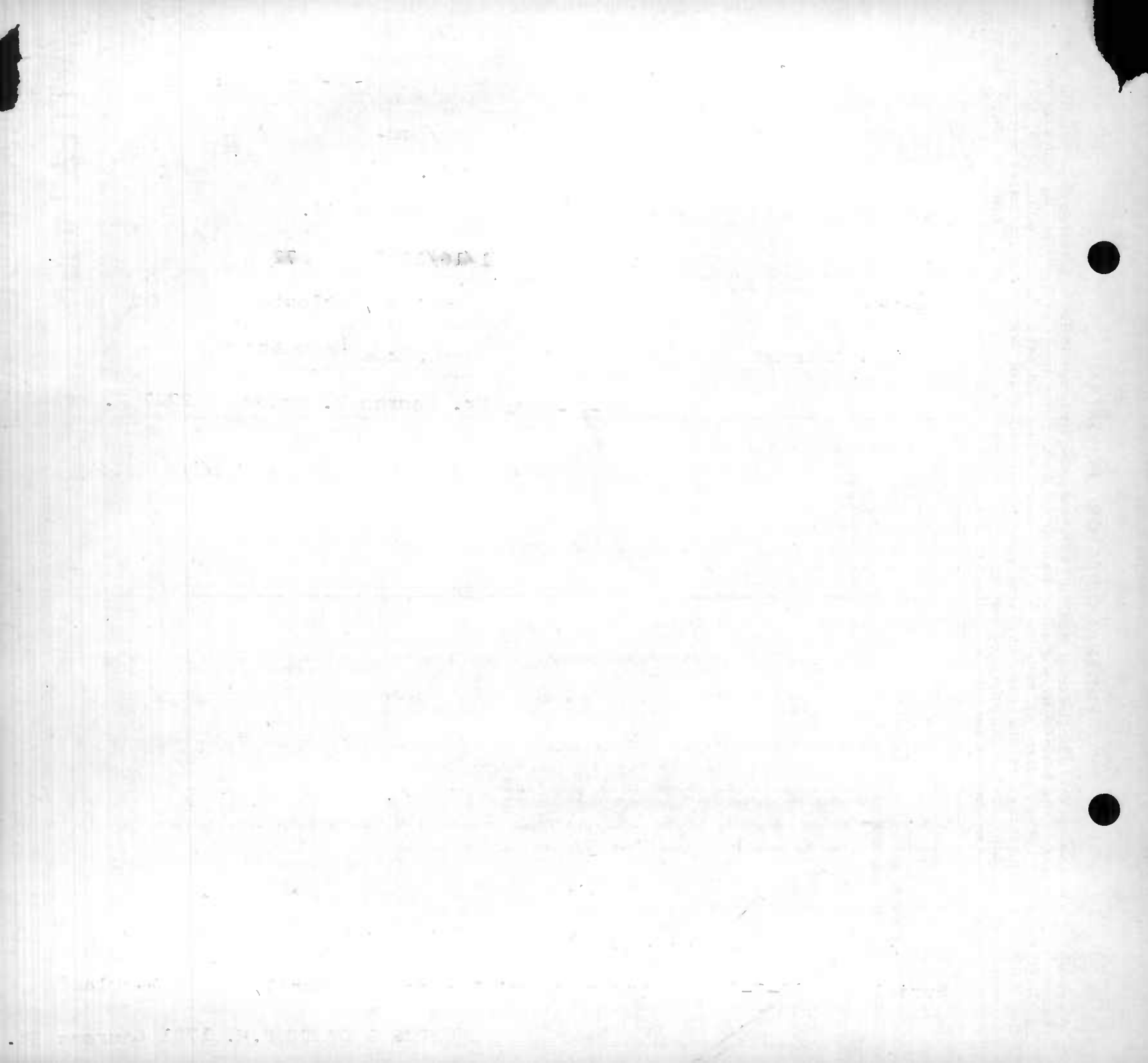
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4618

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. No. 1264 68- 4618

BIRTH NO.		1. NAME OF DECEASED <b>K. Annie McCoy</b> (Type or Print)		2. DATE AND HOUR OF DEATH <b>4-30-68-----11:40 AM</b>	
3. PLACE IN <b>BALTIMORE, MARYLAND</b> , WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-37</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Bolton Hill Nursing &amp; Convalescent Center</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>2727 Rosedale St.</b>	
5. SEX <b>F</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/16/1896</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Georgia, Atlanta</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>White, Alexander</b>		14. MOTHER'S MAIDEN NAME <b>Penn, Emma Mayweather</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-30-0202A</b>		17. INFORMANT ADDRESS <b>Mr. George E. McCoy 2727 N. Rosedale</b>	
18. <b>188X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of Bladder</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b>	
1810 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 16</b> 19 <b>68</b> to <b>April 30</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>April 30</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A.C. Alevizatos, M.D.</b>		23B. DATE SIGNED <b>April 30, 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>A.C. ALEVIZATOS, M.D.</b>	
23D. ADDRESS <b>1209 ST. PAUL ST. Baltimore, Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-3-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Carver Memorial Park</b>		24D. LOCATION <b>Laurel, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>	
25B. NAME OF REGISTRAR <b>R. E. F. F. F.</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4619 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 4619

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Mary OCTAVIA WILLIS</b>		2. DATE AND HOUR OF DEATH <b>4/30/68 12:18 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>25-32</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY OF MARYLAND</b>			C. CITY OR TOWN <b>BALTIMORE</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>2911 SPELMAN RD</b>		
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-9-1913</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Work</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Wallace Turtle</b>			14. MOTHER'S MAIDEN NAME <b>Annie Turtle</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mr. William Willis</b> ADDRESS <b>2911 Spelman Rd</b>	
18. <b>2309 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Probable Myocardial Infarct</b> (B) <b>ASCID</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>DIABETES</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 HRS</b> <b>6 YRS</b> <b>11</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>260X II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>APRIL 29</b> 19 <b>68</b> to <b>APRIL 30</b> 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>APRIL 30</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William H. Barker, Jr. MD</b> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>4/30/68</b>
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM H. BARKER, JR MD</b> DEGREE				23D. ADDRESS <b>UNIV. MD. HOSPITAL BALTO., MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5-4-68</b>	24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A. A. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F.H.</b> ADDRESS <b>1701 Laurens</b>	

42

7-8-1913

North Carolina

Forest Service

W. W. Williams

W. W. Williams

W. W. Williams

W. W. Williams

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-4620

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DENNIS J. WILSON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 28, 1968</b> Hour: <b>2:25 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>2551 W. Coldspring Lane</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year <b>April 28, 1968</b> Hour: <b>2:25 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>9-21-44</b>		10. AGE (In years last birthday) <b>23</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Armco Steel</b>	
15. MOTHER'S MAIDEN NAME <b>MILDRED WILSON</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>220-38-7343</b>		18. INFORMANT <b>Mrs. Delores Wilson</b>	
19. <b>E966 IX</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Stabwound of Chest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>4/28/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>building</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>2551 W. Coldspring Lane</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>4/28/68 2:00 P.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>subj. stabbed during altercation</b>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz M.D.</b>		DATE SIGNED <b>4/29/68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-2-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <b>Alfred E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

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68- 4621

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 4621

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>RICHARDSON, Lewis Edward</b>		2. DATE AND HOUR OF DEATH <b>April 29, 1968</b>   <b>3:35</b> <b>A.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Roofer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, Calvert Co.</b>	
13. FATHER'S NAME <b>Alfred Richardson</b>		14. MOTHER'S MAIDEN NAME <b>Emma Roal</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>2-10-44 to 3-24-47</b>		16. SOCIAL SECURITY NO. <b>216-12-8084</b>		17. INFORMANT <b>Records</b> <b>V. A. Hospital, Baltimore, Md. 21218</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Carcinoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Bronchogenic Carcinoma</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic Carcinoma</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchogenic Carcinoma</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>1 year</b>	
19A. DATE OF OPERATION <b>162.1 II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 19, 1968</b> to <b>April 29, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 29, 1968</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard H. Anderson</i>		23B. DATE SIGNED <b>April 29, 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>RICHARD H. ANDERSON, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-2-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto. National Cem.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24E. ADDRESS <b>V. A. Hospital, Baltimore, Md. 21218</b>			

RECEIVED  
FEB 10 1964

U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250  
OFFICE OF THE SECRETARY  
ATTENTION: ASSISTANT SECRETARY FOR  
GENERAL AFFAIRS  
TELEPHONE: 444-1111  
FACSIMILE: 444-1111  
MAIL ROOM: 444-1111  
RECORDS SECTION: 444-1111  
GENERAL INVESTIGATIVE DIVISION  
FEB 10 1964

MEMORANDUM FOR THE SECRETARY  
SUBJECT: [Illegible]

TO: [Illegible]  
FROM: [Illegible]  
DATE: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]  
4. [Illegible]  
5. [Illegible]  
6. [Illegible]  
7. [Illegible]  
8. [Illegible]  
9. [Illegible]  
10. [Illegible]

[Illegible Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4622</b>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Albino Broccolo</b>		<b>CERTIFICATE OF DEATH</b> <b>2. DATE AND HOUR OF DEATH</b> <b>April 30, 1968</b> <b>6 am</b> M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>209 S. Ann Street</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____ <b>5. CITY OR TOWN</b> <b>Baltimore</b> <b>6. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>7. STREET AND NUMBER</b> <b>209 S. Ann Street</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Feb 17, 1896</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Bethlehem Steel</b>		<b>9. AGE</b> (In years last birthday) <b>72</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Italy</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>
<b>13. FATHER'S NAME</b> <b>Joseph Broccolo</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Teresa Romanagilano</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>213-07-7549</b>		<b>17. INFORMANT</b> <b>Mrs. Philomena Broccolo</b> <b>ADDRESS</b> <b>209 S. Ann Street</b>
<b>18. CAUSE OF DEATH</b>				
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <b>Coronary Occlusion</b> <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arterio Sclerosis Cordis - Vascular Disease</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Emphysema</b> <b>(C) _____</b>		
<b>19A. DATE OF OPERATION</b> <b>4-20-1</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>II</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hour</b>  <b>Unknown</b>  <b>Unknown</b>
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>				
<b>20A. AUTOPSY? (Yes or No)</b> <b>No</b>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>No</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>_____</b>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>_____</b>
<b>21D. TIME OF INJURY (APPROX.)</b> <b>_____</b>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <b>_____</b>
<b>22. I certify that (I) (the hospital) attended the deceased from January 30, 1968 to April 30, 1968, that (I) (we) last saw the deceased alive on April 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <b>Philibert Artigiani</b>		<b>23B. DATE SIGNED</b> <b>4/30/68</b>		<b>23C. PHYSICIAN'S NAME (Type)</b> <b>Philibert Artigiani</b>
<b>23D. ADDRESS</b> <b>2305 Mayfield Ave. Baltimore, Md. 21213</b>		<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		
<b>24B. DATE</b> <b>5-3-1968</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Holy Redeemer</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 2 1968</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Fairbank</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Lilly &amp; Zeiler Inc.</b> <b>ADDRESS</b> <b>1901-07 Eastern Ave.</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4623</b>	
BIRTH NO. <b>68-4623</b>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>Catherine Gerczak</b>			2. DATE AND HOUR OF DEATH <b>4/30/1968</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1300 Gough St.</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/27/96</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Al Kramer</b>		14. MOTHER'S MAIDEN NAME <b>Mary ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-22-2370</b>		17. INFORMANT <b>Catherine Barone (daughter)</b>	
				ADDRESS <b>1300 Gough St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Gastric Ulcers</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes mellitus, Laennec's Cirrhosis</b>					
19A. DATE OF OPERATION <b>4/24/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>bleeding ulcers</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/17/68</b> 19 to <b>4/30/68</b> 19, that (I) <del>(we)</del> last saw the deceased alive on <b>30 April</b> 19 <b>68</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <i>Ira L. Fetterhoff M.D.</i>				23B. DATE SIGNED <b>4/30/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ira L. Fetterhoff, M.D.</b>				23D. ADDRESS <b>South Baltimore Gen. Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-4-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <i>Robert E. Jankowski</i>		25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>	
				ADDRESS <b>1901-07 Eastern Ave.</b>	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

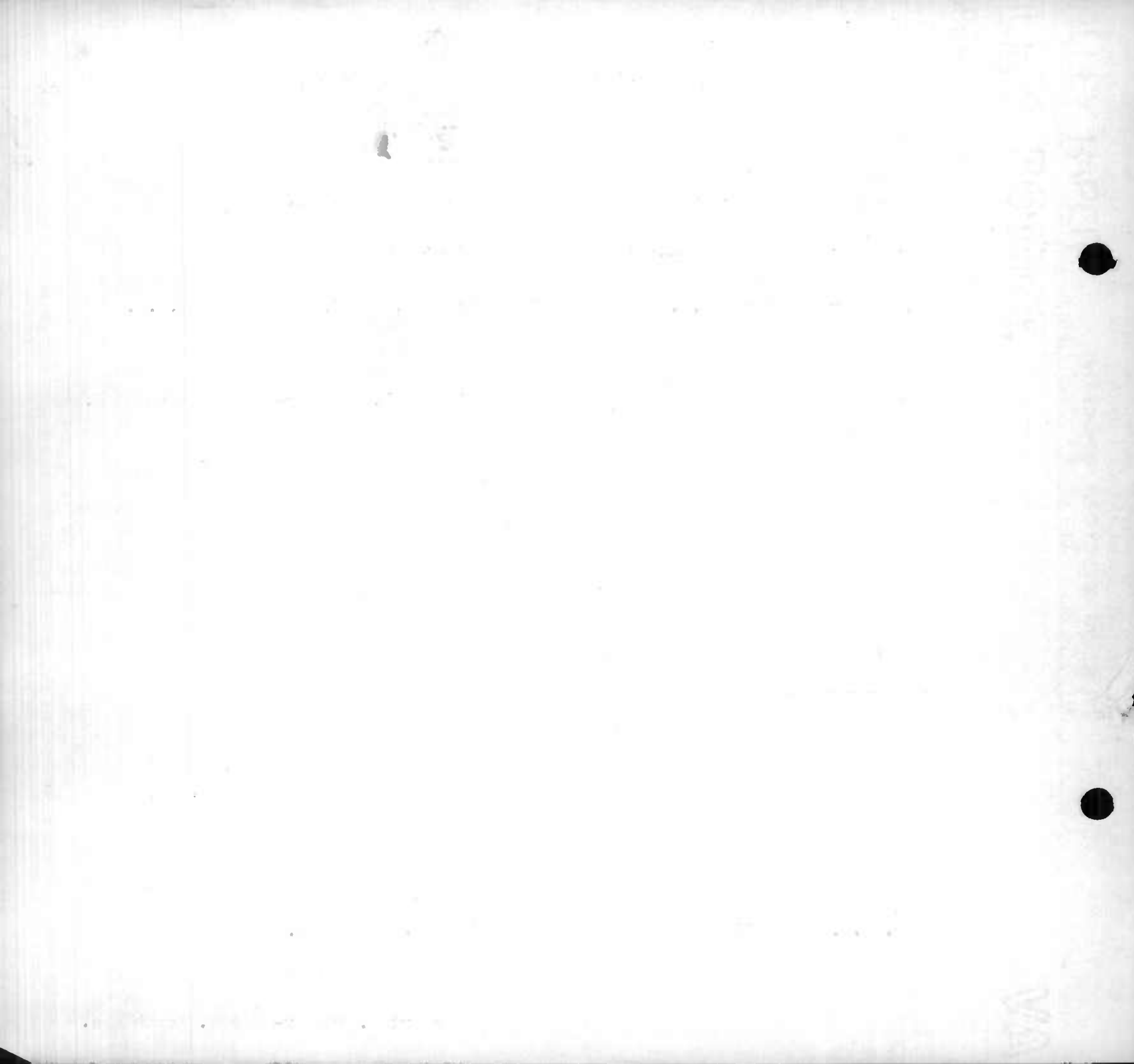


Certificate is to be approved by the Medical Examiner.  
FURNAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>2-360 68-4624</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>68-4624</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>George Vernon Lottier</b>		2. DATE AND HOUR OF DEATH <b>April 27, 1968 18:45 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 Maryland Baptist Home 2801 Rayner Avenue</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>45 01 Wentworth Rd,</b>			
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>6/26/1881</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Letter Carrier</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Postal Service</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond, Virginia</b>	
13. FATHER'S NAME <b>? ? ? ?</b>		14. MOTHER'S MAIDEN NAME <b>Emma</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>D.</b>		17. INFORMANT ADDRESS <b>Lillian L. Lottier-4501 Wentworth Rd.</b>	
MEDICAL CERTIFICATION  18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.4 I</b>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>422.1 II</b>  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>0</b>		CAUSE OF DEATH (A) <b>Arterioscleotic Cardio Vascular Disease</b> DUE TO (B) <b>Old age</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 11,</b> 19 <b>47</b> to <b>Jan. 12,</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Jan. 12,</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>CR. Campbell</b>				23B. DATE SIGNED <b>4/27/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. C.R. Campbell</b>		23D. ADDRESS M.D. <b>1618 W. North Ave.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/1/68</b>	24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter-3035 W. North Ave.</b>	





## FUNERAL DIRECTOR: IMPORTANT

SPRINGFIELD, MASS. OFFICE  
This certificate must be approved by the chief medical examiner's office before the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-346 68-4625				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4625	
BIRTH NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				NATHANIEL BUTLER SR		4/27/68 5:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
THE JOHNS HOPKINS HOSPITAL				MARYLAND		C. CITY OR TOWN D. INSIDE CITY LIMITS	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				4210 EVANS CHAPEL ROAD			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		NEGROID		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2-10-10	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Printer		King Brothers		Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
NATHANIEL BUTLER				KATIE ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				212-03-4913		Mrs. Mary Butler 4210 Evans Chapel Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE ? myocardial infarct, CH, 1 hr			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF: Pul Embolus			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Congestive heart failure years			
				(C) Paget disease years			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
						YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/24 1968 to 4/27 1968				that (I) (we) last saw the deceased alive on 4/27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED			
G. M. Vincent M.D., DEGREE				4/27/68			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
G.M. VINCENT				THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5/2/68		Arbutus Memorial Park		Arbutus Balto Co Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 2 1968		Herbert E. Nutter		3035 W. North Ave			

X

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-4626</u>
BIRTH NO. <u>68-4626</u>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>Price, Charles Dewitt</u>		2. DATE AND HOUR OF DEATH <u>4-29-68</u> <u>3:40 p.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u> <u>5/6/68</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1314 N. Fulton Avenue</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-00</u>	9. AGE (In years last birthday) <u>68</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dept. Of Education</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>School # 130</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware (Wilmington)</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Perry W. Price</u>		
14. MOTHER'S MAIDEN NAME <u>Anna Welcome</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>216-07-0819</u>		17. INFORMANT <u>Mrs. Hortense C. Price</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (B) <u>ARTERIOSCLEROTIC Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (C) <u>4/29/68</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>April 26,</u> 19 <u>68</u> to <u>April 26,</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 26,</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Dr. Banfield</u>		23B. DATE SIGNED <u>4/29/68</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Banfield</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/30/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Carver Memorial Park</u>
24D. LOCATION <u>Laurel</u>		24E. LOCATION (City, town, or county) (State) <u>Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Tarkenton</u>		25C. FUNERAL DIRECTOR <u>Herbert E. Nutter</u>
25D. ADDRESS <u>3035 W. North Ave</u>				

Letter from Provident Hosp. re date of death (should be April 26, 1968)

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68-4627</span>
H-536 68-4627		<b>CERTIFICATE OF DEATH</b>		
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>HUNTER, RUTH ALICE</i>		4-22-68 2 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>North Charles General Hosp.</i>		A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <i>129 Winters Lane</i> 21228		
5. SEX <i>FEMALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-13-13</i>	9. AGE (In years last birthday) <i>54</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DOMESTIC</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>PRIVATE FAMILY</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE COUNTY, MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>CHARLIE CASLO (D)</i>		
14. MOTHER'S MAIDEN NAME <i>OTELIA WOODRIDGE (D)</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>218-26-8126</i>		17. INFORMANT <i>THR. LOUIS HUNTER - 129 WINTERS LA.</i>		
18. <i>322X I</i>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Brain Abscess</i>		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. <i>342X II</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>No</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>4-17-1968</i> to <i>4-22-1968</i> , that (I) (we) last saw the deceased alive on <i>4-22-68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>German de la Torre M.D.</i>		23B. DATE SIGNED <i>4-22-68</i>		23C. PHYSICIAN'S NAME (Type) <i>GERMAN DE LA TORRE, MD</i>
23D. ADDRESS <i>North Charles General Hospital</i>		24. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		
24B. DATE <i>4/25/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>ARBUTUS MEMORIAL PARK</i>		24D. LOCATION (City, town, or county) (State) <i>ARBUTUS BALTO CO, MD</i>
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 2 1968</i>		25B. NAME OF REGISTRAR <i>R. E. Jackson</i>		25C. FUNERAL DIRECTOR <i>HERBERT E. NUTTER</i> ADDRESS <i>3035 W. NORTH AVE</i>

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68-4628</b>	
BIRTH NO. <b>A-652</b>		68-4628	
1. NAME OF DECEASED (Type or Print) <b>HATTIE BERTHA ARMSTRONG</b>		2. DATE AND HOUR OF DEATH <b>4. 26. 68</b> <b>2:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>21216</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 LUTHERAN HOSPITAL OF MARYLAND</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>3208 VICKERS ROAD</b>	
5. SEX <b>♀</b>	6. RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>2-26-02</b> 9. AGE (In years lost birthday) <b>66</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hautarculist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Nursery</b>	11. BIRTHPLACE (State or foreign country) <b>Norman, North Carolina</b>
13. FATHER'S NAME <b>Precher Bonner</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Chambers</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>241-52-9787</b>	17. INFORMANT <b>Mr. Walter T. Armstrong</b> ADDRESS <b>3208 Vickers Road Balto, Md - 21216</b>
18. <b>433,912,509</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL ARTERIO SCLEROSIS &amp; THROMBOSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>+ Hypertensive Arteriosclerosis</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiovascular Disease</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes Mellitus &amp; Bleeding</b>			
19A. DATE OF OPERATION <b>332X</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-18-68</b> to <b>4-26-68</b> , that (I) (we) last saw the deceased alive on <b>4-26-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <del>(did)</del> view the body after death.			
23A. SIGNATURE <b>P. Aziz, M.D.</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>P. Aziz, M.D.</b>		23D. ADDRESS <b>730 ASHBURTON ST. BALTIMORE, MD 21216</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/30/68</b>	24C. NAME of CEMETERY or CREMATORY <b>Saint Luke Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Pine Hurst, North Carolina</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter 3035 W. North Ave</b>

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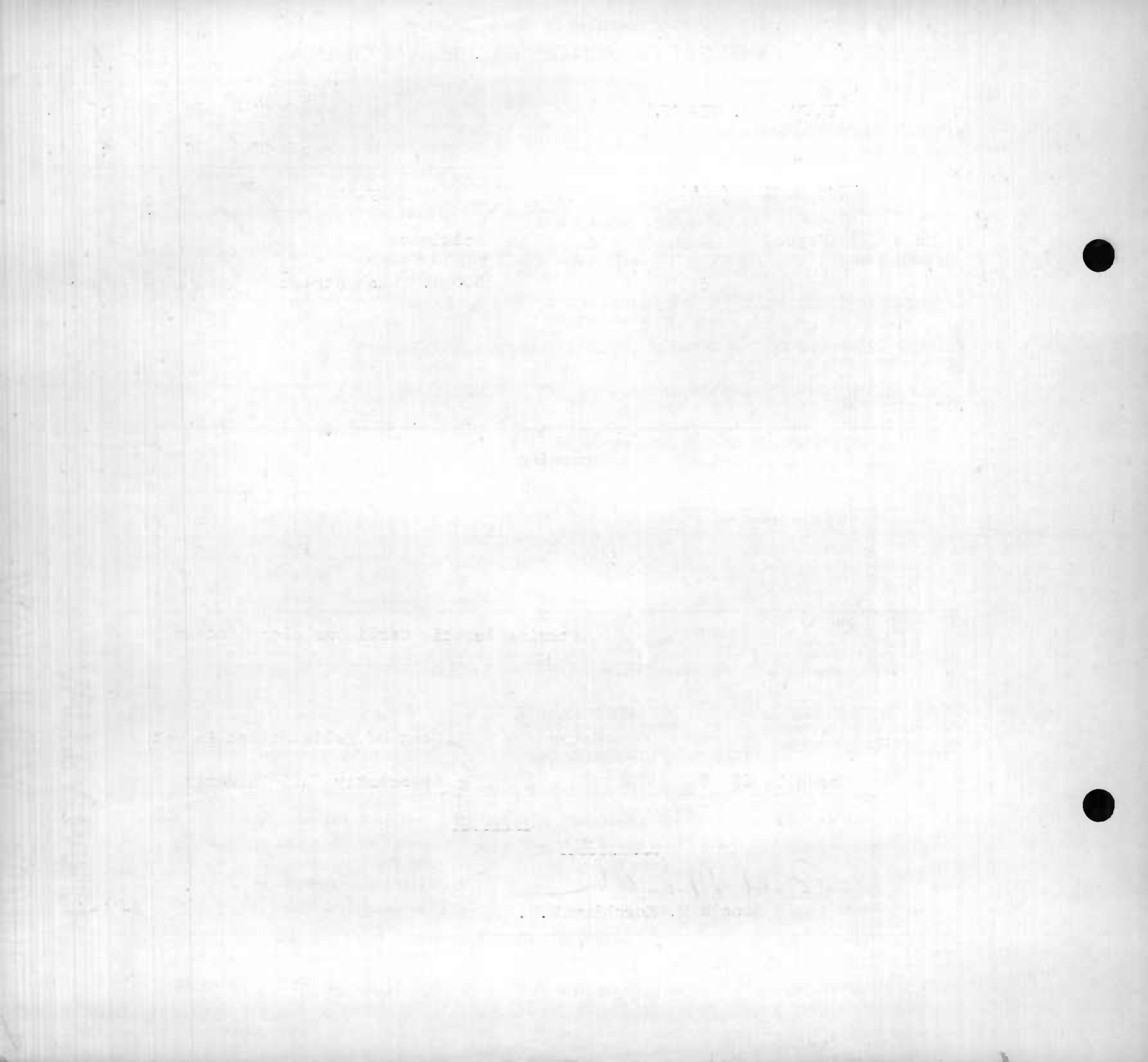
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T-234 68-4629 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-4629

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM R. TISDALE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 22, 1968 Hour 9:50 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 CITY MORGUE (DOA)		3. DATE PRONOUNCED DEAD Month Day Year March 22, 1968 Hour 9:50 A.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH	10. AGE (In years last birthday) 64	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1500 N. Eutaw Street EUTAW PL	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. I E 910.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Drowning (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
E 929.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Arteriosclerotic Cardiovascular Disease			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Water		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Foot of Fells Street in water 2-03	
22D. TIME OF INJURY (APPROX.) March ? 68 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Apparently fell in water	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <u>Ronald N. Kornblum</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-17-68 ASSOCIATE MEDICAL EXAMINER					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-30-68		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. MAY 2 1968		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



M-324

68-4630

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-4630

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WILLIAM

MITCHELL

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

April 9, 1968

10:45 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

male

7. RACE

negro

B. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

10. AGE (In years  
last birthday)

52

# Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

527 Pearl Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Fatty Alteration of Liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/10/68

EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

4-30-68

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAY 2 1968

Robert E. Farber, M.D.

MORTUARY SERVICE - BCHD

BCHD



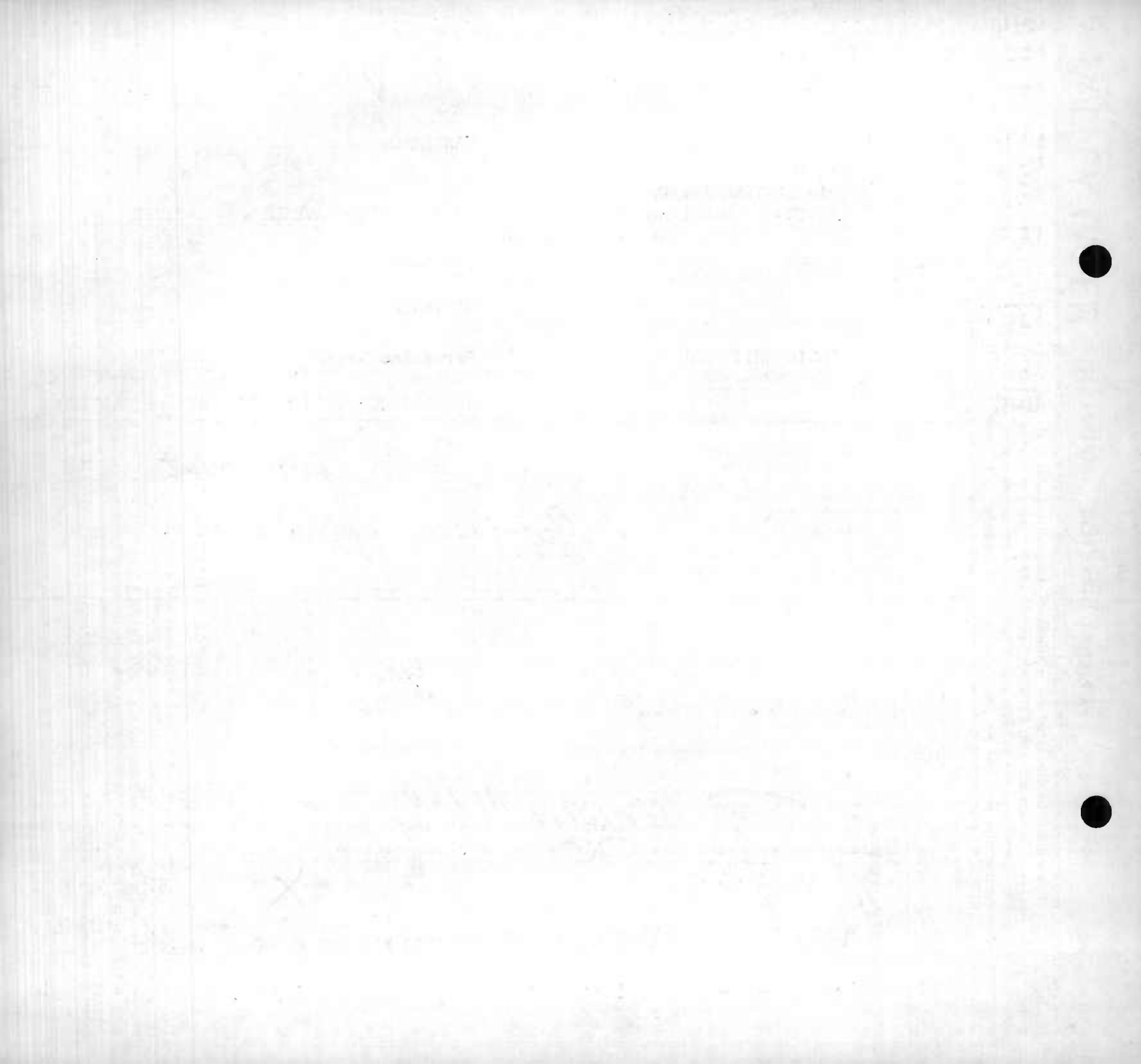
W-330 68-4631  
CERTIFICATE OF DEATH

BIRTH NO. 68-06055		1. NAME OF DECEASED (Type or Print) BABY BOY WHITEHEAD		2. DATE AND HOUR OF DEATH 4/14/68 9:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3904 CRANSTON AVENUE #21229	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-13-68	9. AGE (In years last birthday) 23	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIE WHITEHEAD			
14. MOTHER'S MAIDEN NAME Bernadine Snead		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD			
18. CAUSE OF DEATH					
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
18B. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio respiratory arrest Central nervous system apnea 18C. DUE TO, OR AS A CONSEQUENCE OF:					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4/13/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/13/68 1968 to April 14 1968, that (I) (we) last saw the deceased alive on April 14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE RAQUEL V. MONTEZUMA				23B. DATE SIGNED 4/14/68	
23C. PHYSICIAN'S NAME (Typed) RAQUEL V. MONTEZUMA				23D. ADDRESS BCH-4940 EASTERN AVENUE Baltimore, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 4-15-68		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAY 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL	

## FUNERAL DIRECTOR: IMPORTANT

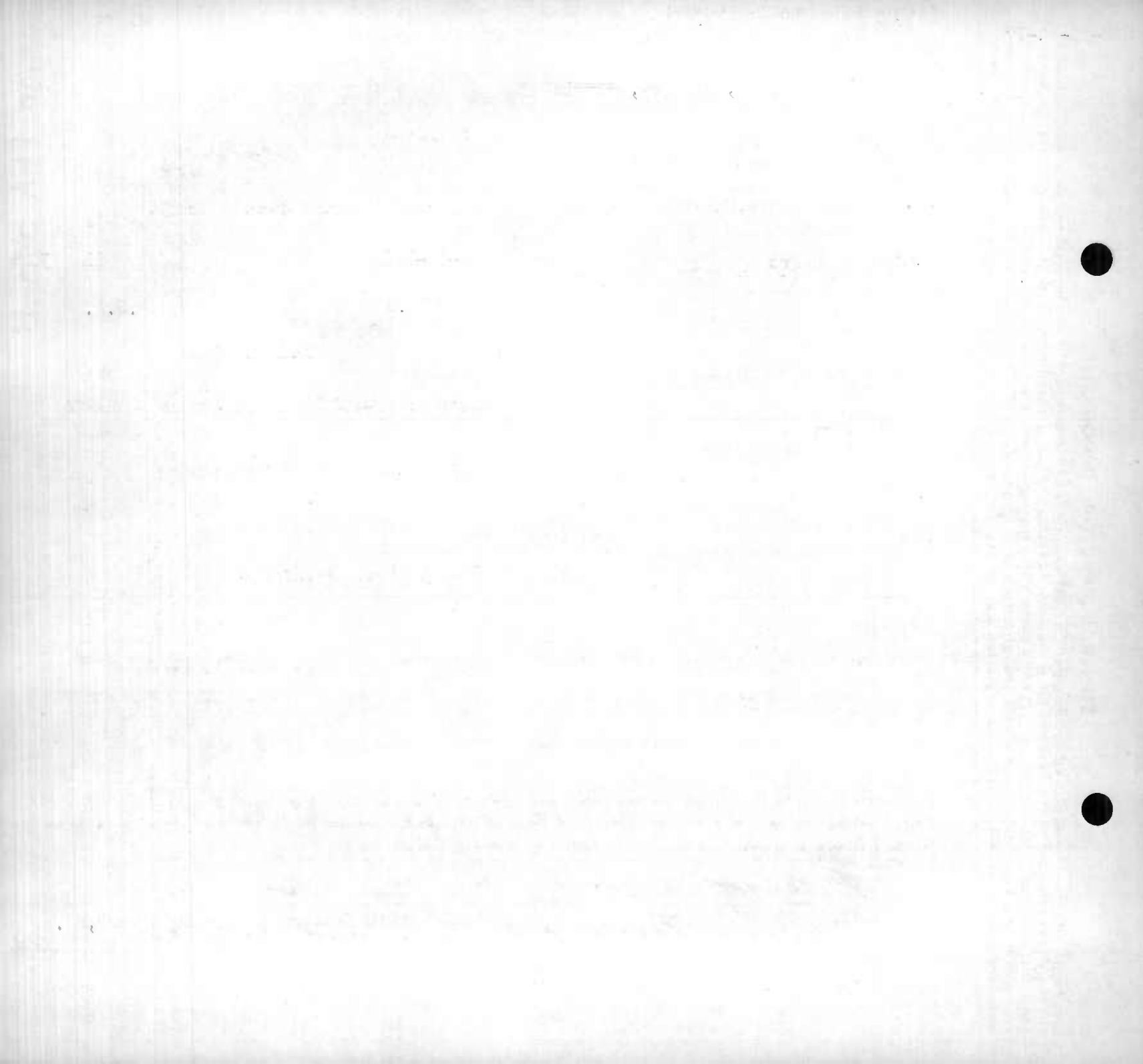
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-130		68-4632		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-46324	
BIRTH NO. 68-07011		1. NAME OF DECEASED (Type or Print) Lovitte, Baby Boy, Gloria		2. DATE AND HOUR OF DEATH 4-19-1968		5 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore		INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 31		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		E. STREET AND NUMBER 119 South Barre Street 21230					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1968	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Gloria Lovitte					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS Records: BCH-4940 Eastern Avenue 21224			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VENTRICULAR HEMORRHAGE (B) PREMATUREITY? (C) Respiratory Distress Syndrome						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4-18-1968 to 4-19-1968, that (I) (we) last saw the deceased alive on 4-19-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature] M.D. DEGREE				23B. DATE SIGNED 4-19-68					
23C. PHYSICIAN'S NAME (Type) Nahum French, M.D.		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. Baltimore City Hospital 21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 4-22-68		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. (State) 21224	
25A. DATE REC'D BY HEALTH DEPT. MAY 2 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR		HOSPITAL DISPOSAL			

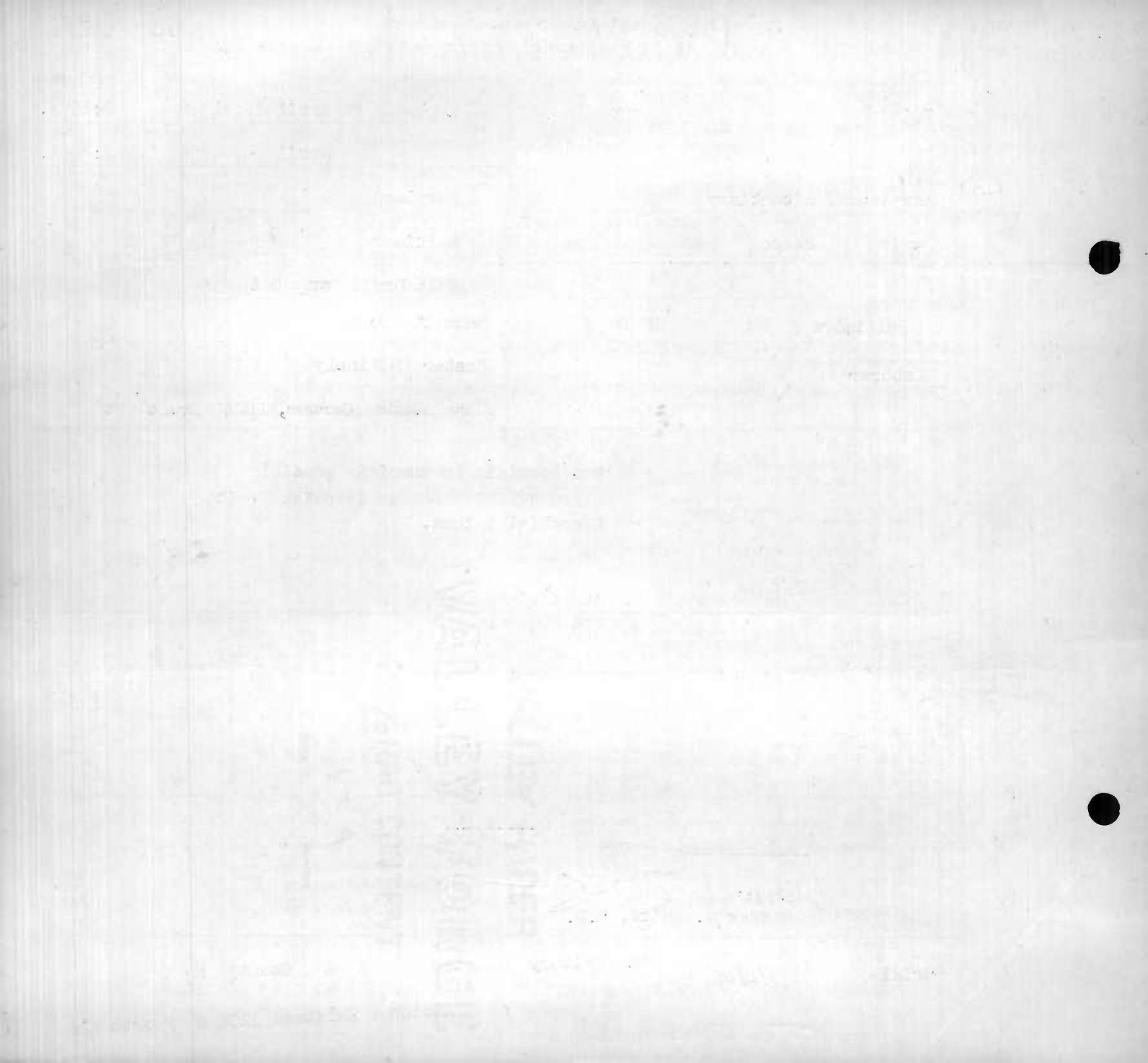


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ISAAC BOYD</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 30, 1968</b> Hour <b>7:15 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Maryland Penitentiary</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 30, 1968 8:30 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>male</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday) <b>35</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF <b>USA</b> WHICH COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. FATHER'S NAME <b>Samuel Boyd</b>		15. MOTHER'S MAIDEN NAME <b>Heater McKinsly</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs. Addie Carter, 2024 Brunt St</b>		ADDRESS	
19. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Non Specific Pneumonitis possibly associated with Bronchial Asthma.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <del>XXXXXXXXXXXXXXXXXXXX</del> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>4/30/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/4/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Ave</b>		ADDRESS	



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68-4634 BALTIMORE CITY HEALTH DEPARTMENT

68-4634

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 68-05494

1. NAME OF DECEASED (Type or Print) <b>CARLENE J. PATTERSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 26, 1968</b> <b>10:25 AM.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2933 Riggs Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 26, 1968</b> <b>10:25 AM.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>3/26/68</b>		10. AGE (In years last birthday) <b>1</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Herbert Patterson</b>		14. MOTHER'S MAIDEN NAME <b>Marie Clark</b>	
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Miss Marie Patterson</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coarctation of aorta</b>		20. CAUSE OF DEATH <b>Coarctation of aorta</b>	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>754.6 II</b>		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
23A. DATE OF OPERATION		23B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23C. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		23D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23E. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		23F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23G. HOW DID INJURY OCCUR?		23H. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23I. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23J. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
23K. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		23L. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23M. ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		23N. DATE SIGNED <b>4-26-68</b>	
23O. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		23P. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/2/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <b>R. E. E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		25D. ADDRESS <b>1206 W North Ave</b>	





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4635</b>	
<div style="display: flex; justify-content: space-between;"> <span>W-623</span> <span>68-4635</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Rosie WRIGHT</b>		2. DATE AND HOUR OF DEATH <b>4/28/68</b> <b>16:30</b> <b>P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b>			C. CITY OR TOWN <b>Baltimore</b> E. STREET AND NUMBER <b>1074 W. Fannum Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/10/10</b>	9. AGE (In years lost birthday) <b>58</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Chester S Carolina</b>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <b>Molly</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Annie Mae Briscoe</b> ADDRESS <b>1074 Sarahann St</b>	
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Septic Shock</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Decubitus Ulcer</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Diabetes Mellitus</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>3/11/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diabetic Craniopharyngeal Decubitus</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>3/12/68</b> 19 to <b>4/28</b> 19 <b>68</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>4/28</b> 19 <b>68</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Lloyd B. Mandel M.D.</b> DEGREE			23B. DATE SIGNED <b>4/28/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Lloyd B. Mandel M.D.</b> DEGREE
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>5/4/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Cemetry</b>
24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>			25A. DATE RECEIVED BY HEALTH DEPT. <b>MAY 2 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>			25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b> ADDRESS <b>1206 W North Ave</b>		

1870

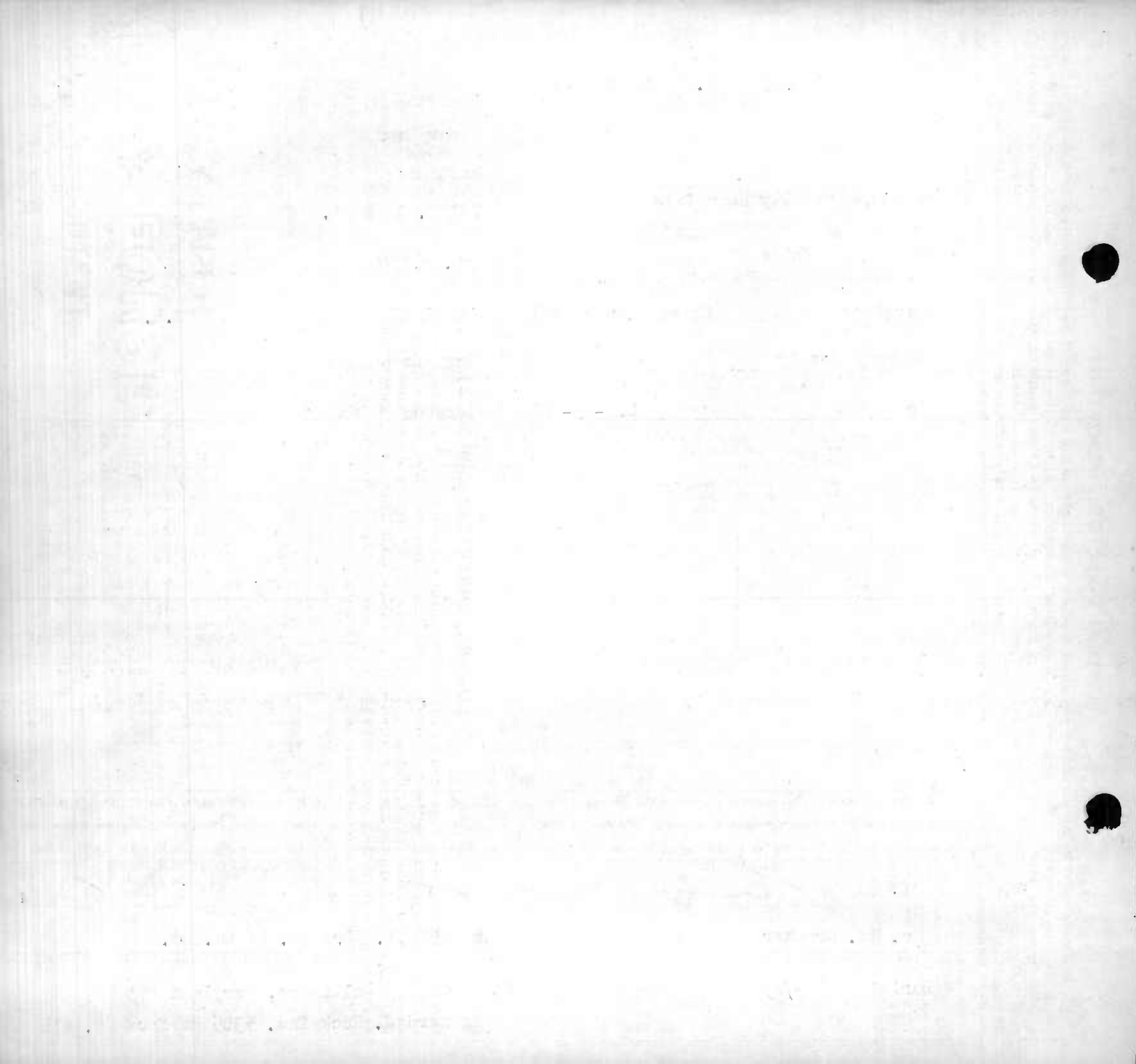
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300 68-4636 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4636	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Millard F. Beatty Sr</b>		2. DATE AND HOUR OF DEATH <b>May 1 1968</b> <span style="float: right;">12:30 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>3/ Baltimore City Hospitals</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>731 E. 36th St.</b>		5. SEX <b>Male</b>		6. RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 28, 1905</b>		9. AGE (in years last birthday) <b>62</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Crown Cork &amp; Seal</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Harry J Beatty</b>		14. MOTHER'S MAIDEN NAME <b>Serrrena Wallace</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-09-7914</b>		17. INFORMANT <b>Florence M Beatty</b> Same	
18. <b>394.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Rheumatic Heart Disease</b> <b>Mitral Stenosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>410x II</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> to <b>May 1, 1968</b> , that (I) (we) last saw the deceased alive on <b>March 29, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Wm. H. Grenzer</b>		23B. DATE SIGNED <b>5.2.68</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Wm. Grenzer</b>		23D. ADDRESS <b>k 1520 E. 33rd St. Balto. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/4/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Rd. #14</b>		25D. ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Arthur Joseph Baker

2. DATE AND HOUR OF DEATH

April 26, 1968 12:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

US Public Health Service Hospital  
3100 Wyman Pk. Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md. Allegany Co. 51-00

C. CITY OR TOWN D. INSIDE CITY LIMITS?  
Frostburg YES ☐ NO ☒

E. STREET AND NUMBER  
RFD 1 Box 207

5. SEX M 6. RACE W 7. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 2/15/04 9. AGE (In years last birthday) 64  
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10B. KIND OF BUSINESS OR INDUSTRY Celanese 11. BIRTHPLACE (State or foreign country) Md. Mt. Savage, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Arthur Joseph Baker 14. MOTHER'S MAIDEN NAME Theresa Bridges

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No N.S.A. 16. SOCIAL SECURITY NO. 215-07-5165 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.

18. CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myelogenous leukemia 3 wks.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

204.3 II Atherosclerosis of the coronary arteries Years  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

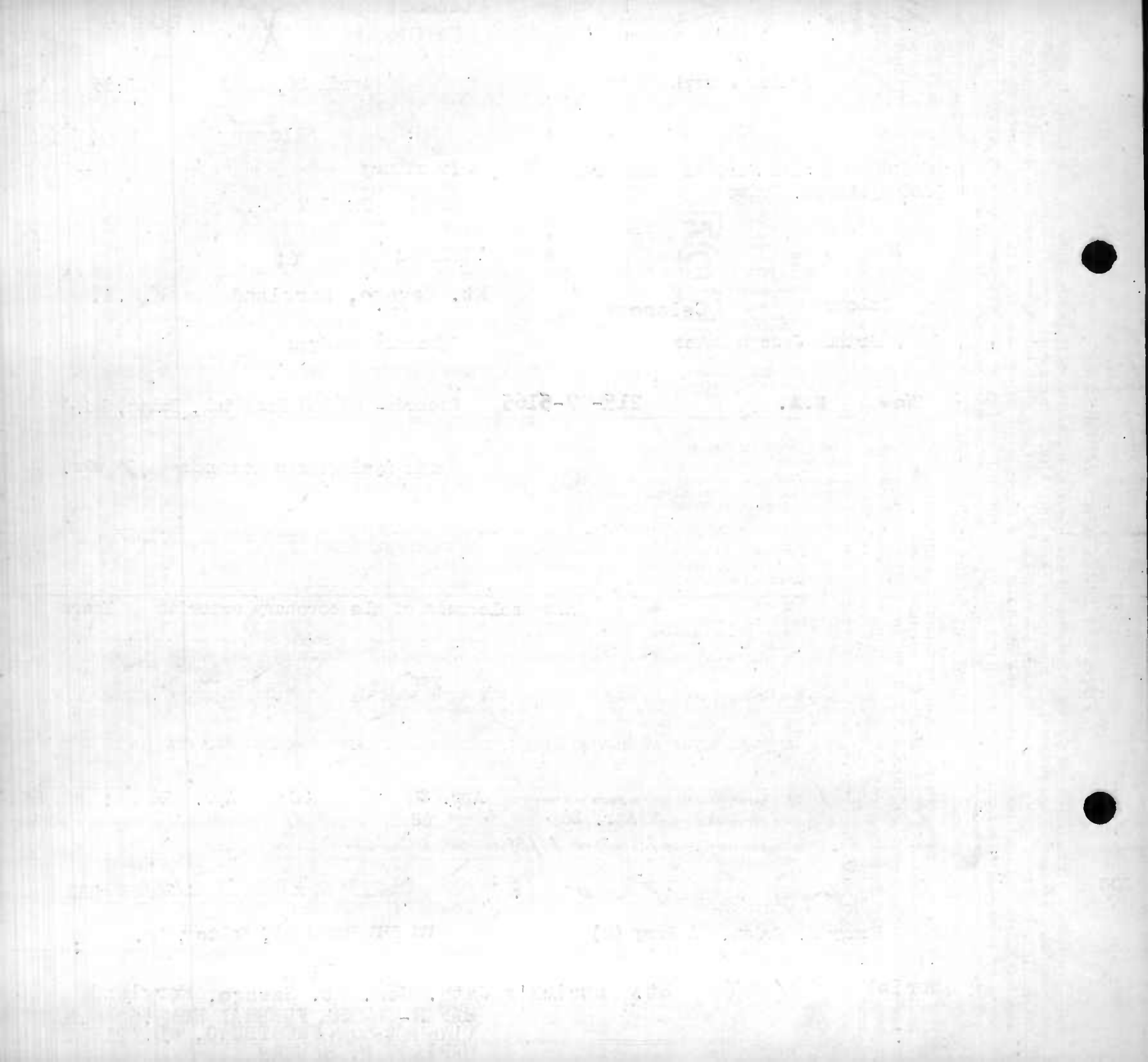
22. I certify that (I) (this hospital) attended the deceased from Apr. 5 19 68 to Apr. 26 19 68, that (I) (we) last saw the deceased alive on Apr. 26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Henry S. Crist, MD DEGREE 23B. DATE SIGNED 4/26/68 RGB

23C. PHYSICIAN'S NAME (Type) Henry S. Crist, SA Surg (R) 23D. ADDRESS US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4/29/68 24C. NAME OF CEMETERY OR CREMATORY St. Patrick's Cath. Cem. Mt. Savage, Maryland 24D. LOCATION (City, town, or county) (State) Frostburg, MD.

25A. DATE REC'D BY HEALTH DEPT. MAY 2 1968 25B. NAME OF REGISTRAR Robert E. Sowers 25C. FUNERAL DIRECTOR ADDRESS HAFER-SOWERS FUNERAL HOME, 60 W. MAIN FROSTBURG, MD. 21532



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 4638</b>	
BIRTH NO. <b>Y-520</b>		<b>68- 4638</b> <b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>HEZEKIAH YOUNG</b>			2. DATE AND HOUR OF DEATH <b>4/30/68</b> <b>6<sup>00</sup> P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>824 N. CAROLINE ST.</b>		
5. SEX <b>MALE</b> <b>NEGRO</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-6-1887</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>American Sugar Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Chester, S. Carolina</b>	
13. FATHER'S NAME <b>John Young</b>			14. MOTHER'S MAIDEN NAME <b>MAMIE YOUNG</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-03-6544</b>		17. INFORMANT ADDRESS <b>Mrs. Carrie Young 824 N. Caroline St. 21205</b>	
18. <b>560.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>S/P EXPLORATORY</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>570.5 II</b>					
19A. DATE OF OPERATION <b>3/24/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTESTINAL OBSTRUCTION</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/23/68</b> 19 <b>68</b> to <b>4/30</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/30/68</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John T. Flaherty</b>			23B. DATE SIGNED <b>4/30/68</b>		23C. PHYSICIAN'S NAME (Type) <b>JOHN T. FLAHERTY</b>
23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5-4-68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>1735 Harford Ave. 21213</b> <b>Marshall W. Jones, Jr.</b>	



9/20/00

10/20/00

10/20/00

10/20/00

10/20/00

10/20/00

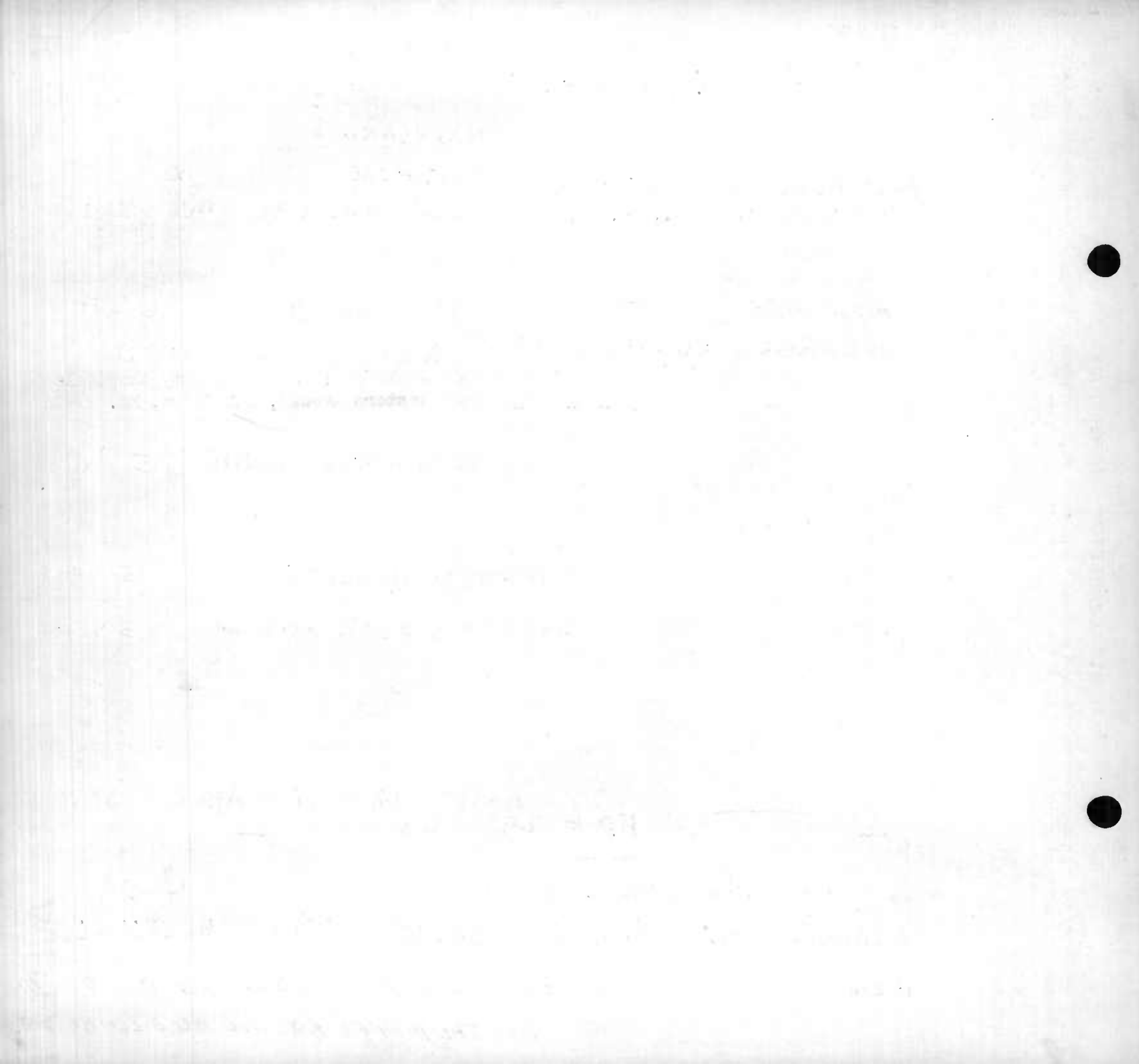
John T. McKinley

47-90-44  
IW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 7-463				68-4639				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4639			
1. NAME OF DECEASED (Type or Print) <b>ELSIE E. FLUHART</b>				2. DATE AND HOUR OF DEATH <b>4/29/68 12:10 P.M.</b>											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Balto., Md. 21224</b>				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2241 EASTERN AVE 21231</b>											
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>3-31-01</b>		9. AGE (In years lost birthday) <b>67</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>GEORGE RUSSELL</b>				14. MOTHER'S MAIDEN NAME <b>NELLIE KENNEDY</b>				17. INFORMANT <b>RECORDS: Baltimore City Hospitals</b> <b>4940 Eastern Avenue, Baltimore, Md. 21224</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO —</b>				16. SOCIAL SECURITY NO. <b>212-30-7851-T</b>											
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DIABETES MELLITUS</b>				CAUSE OF DEATH <b>BRONCHOPNEUMONIA</b> <b>DIABETES MELLITUS</b> <b>ANEMIA, 20 TO CHRONIC IWF.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b> <b>15 years.</b> <b>3 years.</b>							
19A. DATE OF OPERATION <b>260x II</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>YES</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>April 24 1968</b> to <b>April 29 1968</b> , that (I) (we) last saw the deceased alive on <b>April 29 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE <b>Graciela S. Alarcon</b>				23B. DATE SIGNED <b>4-29-68</b>											
23C. PHYSICIAN'S NAME (Type) <b>GRACIELA S. ALARCON</b>				23D. ADDRESS <b>4940 Eastern Avenue, Balto., Md. 21224</b>											
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>MAY 5 68</b>				24C. NAME OF CEMETERY or CREMATORY <b>ST PAUL'S CEMETERY</b>				24D. LOCATION (City, town, or county) (State) <b>CARDIFF AVE BALTO MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 2 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>				25C. FUNERAL DIRECTOR <b>THE DIPPEL BROS INC 1800 E LOMBARD ST.</b>							



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 4640

BIRTH NO.

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

GUIDO B. EGUES Equez

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
OR INSTITUTION ADDRESS OR LOCATION)

St. Agnes Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

April 27, 1968

3:12 A.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

MONTGOMERY

6. SEX

Male

7. RACE

White

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Silver Spring

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Oct. 22, 1934

10. AGE (In years  
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

11649 Lockwood Drive

11. BIRTHPLACE (State or foreign country)

Ecuador

12. CITIZEN OF  
WHAT COUNTRY?

Ecuador

13. FATHER'S NAME

Francesco Equez

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Jr. Inspector

14B. KIND OF BUSINESS OR INDUSTRY

Chemical Co.

15. MOTHER'S MAIDEN NAME

Carmella Equez

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

yes

18. INFORMANT

Mrs. Sylvia Equez 11649 Lockwood Drive  
Silver Spring, Maryland

19.

E 812.0 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Craniocerebral injuries

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E 816.4 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

highway

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

U.S. Rte. #1 - 1/2 mile south of Rte. 176

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

4-27-68 12:40 A. m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Driver in auto-auto collision

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 27, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-30-68

24C. NAME of CEMETERY or CREMATORY

Gate of Heaven Cemetery

24D. LOCATION (City, town, or county)

Silver Spring, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT

MAY 2, 1968

25B. NAME OF REGISTRAR

Robert E. Tarkenton

25C. FUNERAL DIRECTOR

John E. Lee, Jr. 8434 Georgia Ave  
Warner E. Pumphrey, Inc. Silver Spring, Md.

ADDRESS

THE UNIVERSITY OF CHICAGO

OF THE UNIVERSITY OF CHICAGO

OF THE UNIVERSITY OF CHICAGO

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OF THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-630				BALTIMORE CITY HEALTH DEPARTMENT		68- 4641	
68- 4641				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>John Wilson Trout</u>				2. DATE AND/HOUR OF DEATH <u>4/30/68</u> <u>955</u> a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>139 W. Hill St.</u> <u>Baltimore City, md.</u>				C. CITY OR TOWN <u>Baltimore City</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>139 W. Hill St.</u>			
5. SEX <u>M</u>	6. RACE <u>Cau:</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9, 1879</u>		9. AGE (In years lost birthday) <u>88</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Frederick Co. md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown) Trout</u>				14. MOTHER'S MAIDEN NAME <u>(Unknown) Baker</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Daughter</u> <u>Manetta Bryant</u>		ADDRESS <u>139 W. Hill St.</u> <u>Baltimore City</u>	
18. <u>4/12/42-1/85-X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary artery accident</u>		<u>6 months</u>	
				(B) <u>Atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Prostate</u>		<u>10 years</u> <u>4 years</u>	
				(C) <u>Urinary tract infection</u>		<u>2 weeks</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>422.1 II</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N.A.</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>N.A.</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N.A.</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N.A.</u>			
21D. TIME OF INJURY (APPROX.) <u>N.A.</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>N.A.</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>April 15</u> 19 <u>68</u> to <u>April 30</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 29</u> 19 <u>68</u> and that in (my) <u>final</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <u>John Collins Harvey, MD</u>						23B. DATE SIGNED <u>4/30/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN COLLINS HARVEY, MD.</u>						23D. ADDRESS <u>JOHN HARRIS HOSPITAL</u> <u>BALTO, 21205, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-2-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Potomac Methodist Ch. Potomac.</u>		24D. LOCATION (City, town, or county) (State) <u>md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fasham</u>		25C. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>			
ADDRESS <u>7557-Wiscowin</u> <u>Beth. md.</u>							





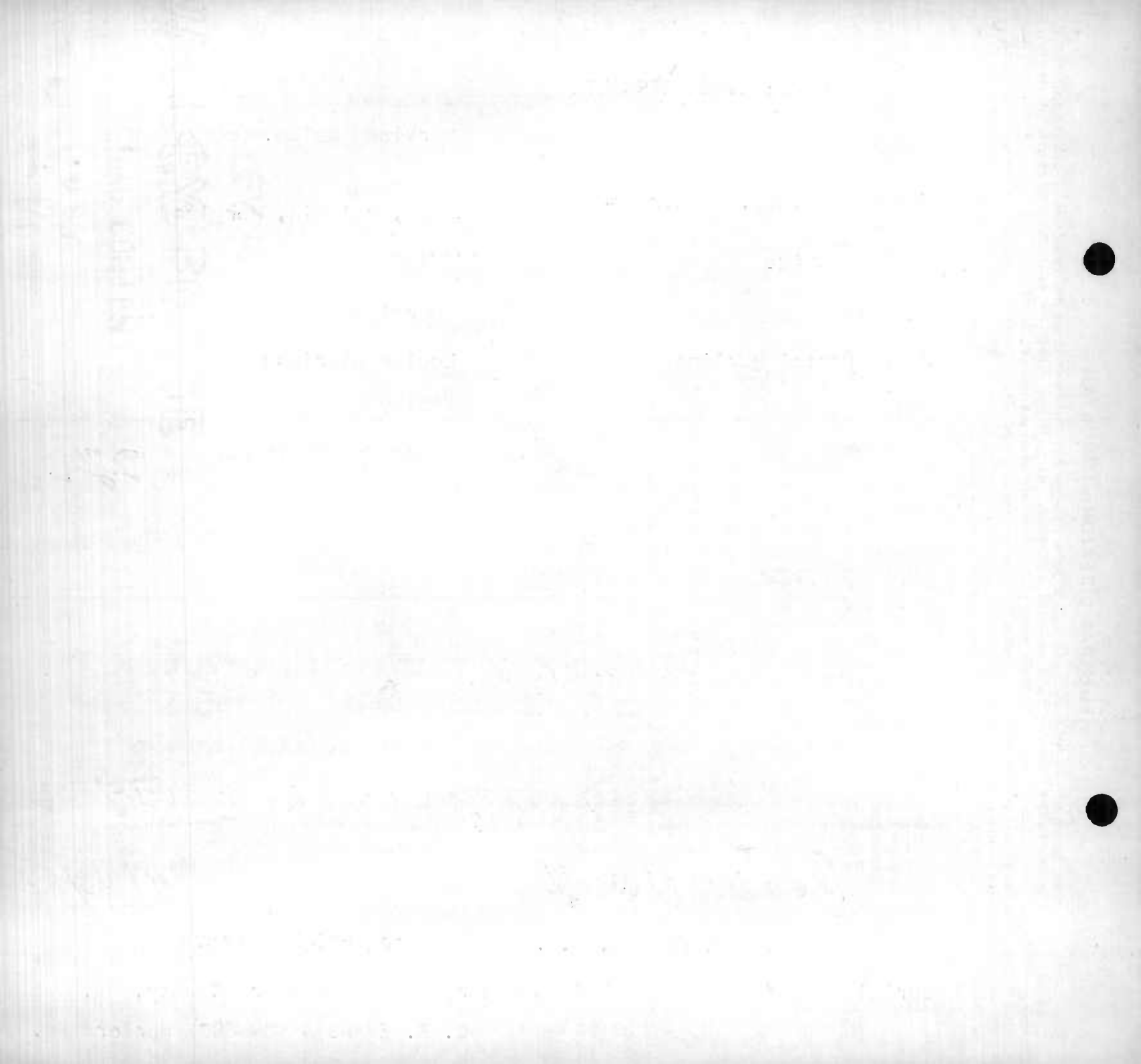
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 4642 CERTIFICATE OF DEATH

REG. NO. 68- 4642

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARIE ETHEL EICHOLTZ</b>		2. DATE AND HOUR OF DEATH <b>4/28/68</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>House of Pines, Belair Road</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto. County</b>			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>Box 62, Baldwin, Maryland</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/5/1900</b>	9. AGE (In years lost birthday) <b>68</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Daniel Hurline</b>				14. MOTHER'S MAIDEN NAME <b>Louise Albright</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>family</b>		ADDRESS	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>carcinoma of colon</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>carcinoma of colon</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/4</b>	
MEDICAL CERTIFICATION 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>15-4-0 II</b>							
19A. DATE OF OPERATION <b>Sept 22 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>rectal &amp; sigmoid</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>mar 13 19 68</b> to <b>april 28 19 68</b> , that (I) (we) last saw the deceased alive on <b>april 27 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Lester N. Kolman</b>				DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4/30/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lester N. Kolman, M.D.</b>				23D. ADDRESS <b>3700 Park Heights Avenue</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>5/1/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Blenheim Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, MA</b>		25C. FUNERAL DIRECTOR ADDRESS <b>C. F. EVANS &amp; SON 8802 Harford Rd.</b>			



FUNERAL DIRECTOR: IMPORTANT

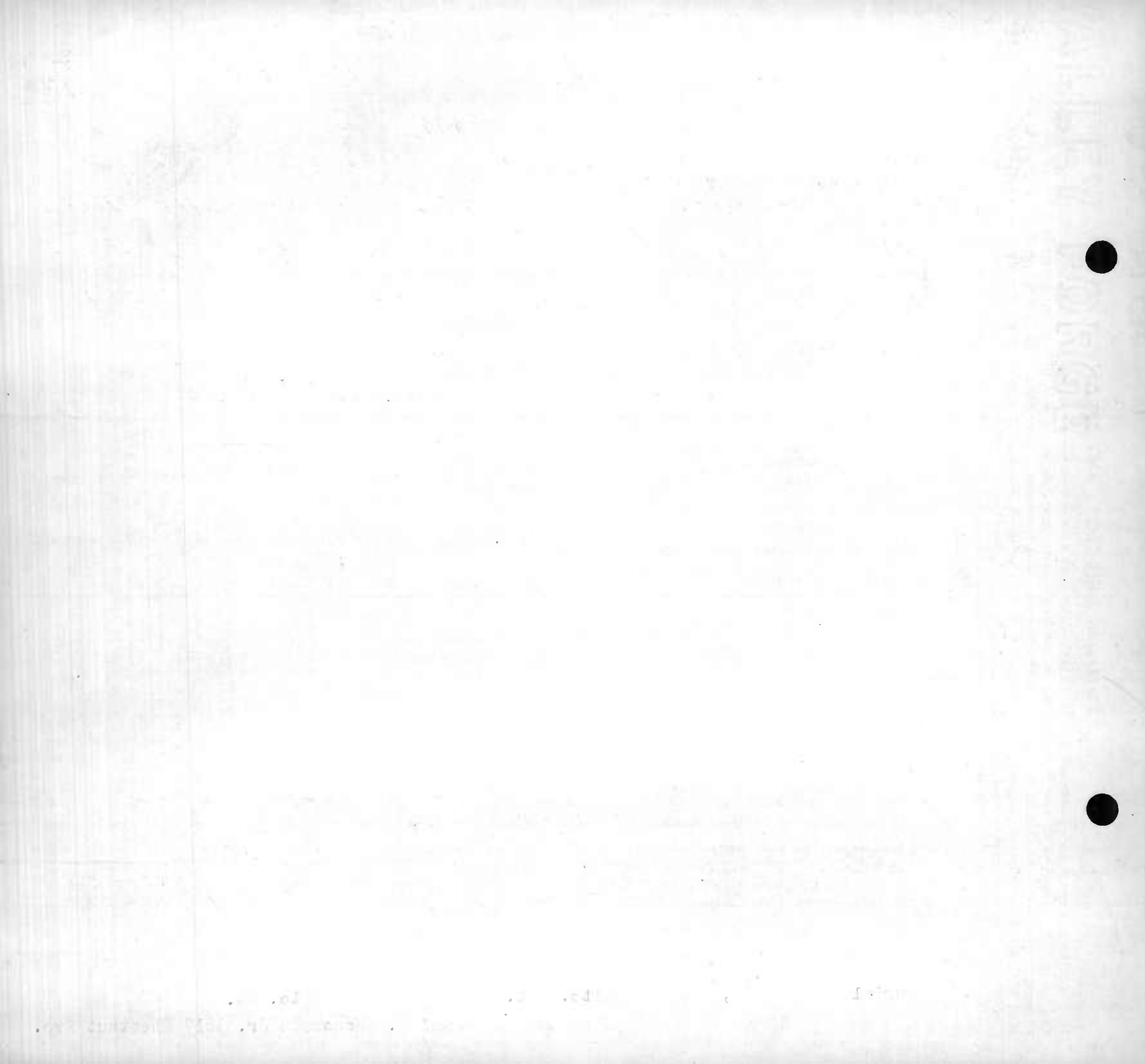
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 68-4643

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>ENNIS C. BUSH</i>		2. DATE AND HOUR OF DEATH <i>5-1-68 3:15</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>-</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 North Charles General Hospital</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>2816 Miles av. Balto - Md - 11</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-31-24</i>	9. AGE (In years lost birthday) <i>43</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>GA.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Harley Bush</i>		
14. MOTHER'S MAIDEN NAME <i>Willie Sneed</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>		
16. SOCIAL SECURITY NO. <i>-</i>			17. INFORMANT <i>Chart. W. Ch.</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>411.9 I</i> <i>II</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Supplic arrest</i> (B) <i>Coronary Insuff due to arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>-</i>		
19A. DATE OF OPERATION <i>420.1</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>II</i>		
20A. AUTOPSY? (Yes or No) <i>0</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>-</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>5-1-1968</i> to <i>5-1-1968</i> , that (I) (we) last saw the deceased alive on <i>5-1-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>3:15 pm</i>					
23A. SIGNATURE <i>Luis E. Rengel</i>				23B. DATE SIGNED <i>5-1-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Harold Bx</i>				23D. ADDRESS <i>-</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>May 6, 1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Balto. Nat.</i>	
24D. LOCATION <i>Balto. Md.</i>		24E. ADDRESS <i>-</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Sisk</i>		25C. FUNERAL DIRECTOR <i>Paul E. Chenoweth Jr.</i>	
25D. ADDRESS <i>3617 Chestnut Ave.</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 4644
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAM H. RUPPERT</b>		2. DATE AND HOUR OF DEATH <b>April 30, 1968</b>   <b>1:45 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b> <b>3324 CALVERT ST.</b> <b>BALTIMORE, MARYLAND</b>		E. STREET AND NUMBER <b>3612 MANCHESTER AVE (15)</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/12/13</b>	9. AGE (In years lost birthday) <b>54</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AUTOMOBILE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>John Ruppert</b>		14. MOTHER'S MAIDEN NAME <b>HANNAH HOMBURG</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-18-5485</b>		17. INFORMANT <b>Mrs. William Ruppert</b> ADDRESS <b>3612 MANCHESTER AVE BALTIMORE, MD 21215</b>	
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b>		CAUSE OF DEATH <b>CONGESTIVE HEART FAILURE</b> (A) IMMEDIATE CAUSE (Due to, or as a consequence of) <b>CORONARY ATHEROSCLEROSIS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>10 years</b> (C) <b>16 hrs</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>		P. <i>Handwritten signature</i>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from <b>April 25, 1968</b> to <b>April 30, 1968</b> , that (we) last saw the deceased alive on <b>April 30, 1968</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.			
23A. SIGNATURE <b>William H. Spencer-Strong, MD</b>		23B. DATE SIGNED <b>April 30, 1968</b>			
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM H. SPENCER-STRONG, MD</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-3-68</b>		24C. NAME OF CEMETERY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. NAME OF REGISTRAR <b>Robert E. Sisk</b>		24F. FUNERAL DIRECTOR <b>Louise Byers</b>	
24G. ADDRESS <b>8728 Liberty Road Randallstown</b>		24H. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		24I. NAME OF REGISTRAR <b>Robert E. Sisk</b>	
24J. FUNERAL DIRECTOR <b>Louise Byers</b>		24K. ADDRESS <b>8728 Liberty Road Randallstown</b>			

John Robert

WATLAND

BALTIMORE

312 W. HESTER AVE (1)

7/19/13 24

WATLAND

HANNA HOME RD

11-18-2008 William Robert

~~WATLAND~~

Confidential

CORPORATE ATTORNEYS

Male (Caucasian)

WATLAND

John Robert

April 20

April 22

April 25

William H. Hester

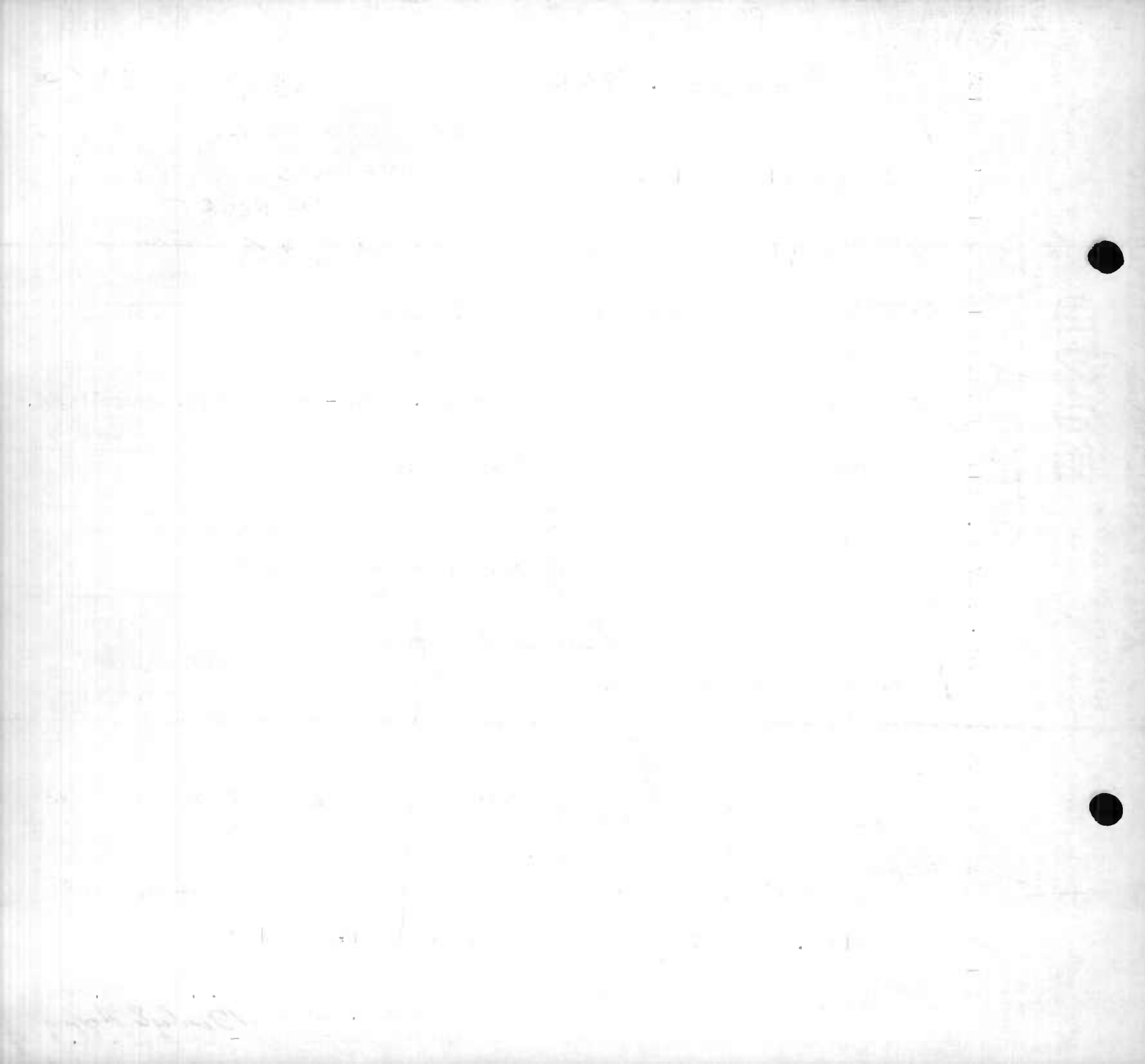
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THIS CASE WAS RELEASED ON APPROVAL BY DR. SPITZ OF THE MEDICAL EXAMINER'S OFFICE

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-4645	
BIRTH NO.		68-4645		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>PEARLIE M. SPEAK</b>		2. DATE AND HOUR OF DEATH <b>4-30-68</b> <b>3 41 P</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>ANNE ARUNDEL</b> <b>52-10</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ANNAPOLIS</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>		D. STREET ADDRESS (If rural, give location) <b>38 OAK COURT</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>5-19-03</b>	9. AGE (In years last birthday) <b>64</b> <del>65</del>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>MATILDA WOLFE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Warren S. Speak - 38 Oak Court, Annapolis, Md.</b>	
18. <b>E948X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>E958X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>PULMONARY INSUFFICIENCY</b>		CAUSE OF DEATH (A) <b>HEMORRHAGE</b> DUE TO (B) <b>RADIONECROSIS @ SUBCLAVIAN AR.</b> DUE TO (C) <b>RADIOTHERAPY FOR SCROFULA IN 1943</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>4-30-68</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ACUTE HEMORRHAGE</b>	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>00-000</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>2-27</b> 19 <b>66</b> to <b>4-30</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-30</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dennis W. Shermeta</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>4-30-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>DENNIS W. SHERMETA</b>		23D. ADDRESS M.D. <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/3/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Hillcrest Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Annapolis A.A. Md.</b>		
25A. DATE RECEIVED BY HEALTH DEPT. <b>MAY 3 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	25C. FUNERAL DIRECTOR <b>Beverley E. Hopping</b> <b>Hopping Funeral Home - Annapolis, Md.</b>			





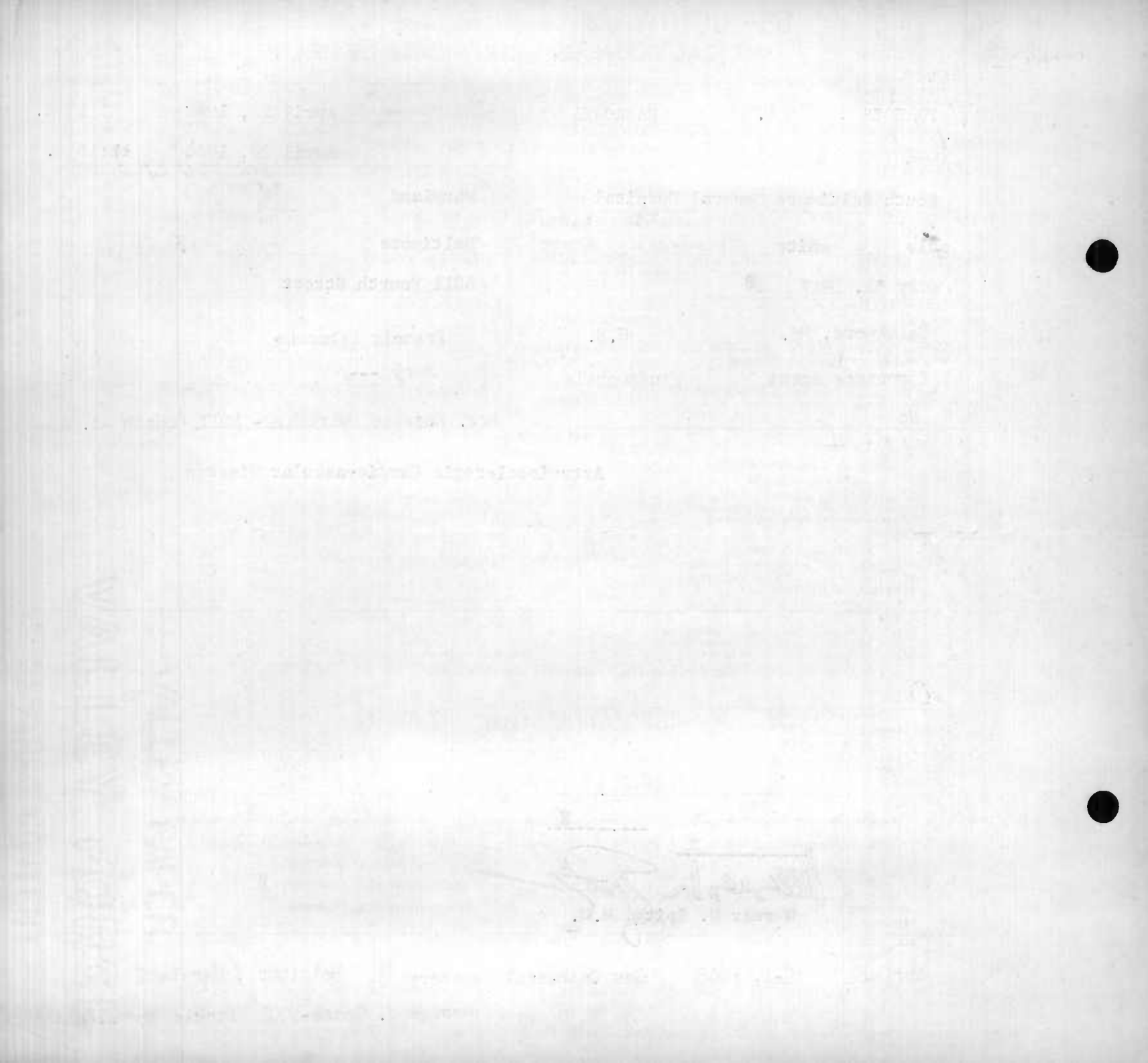
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4646

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FRANCIS L. DABROWKA</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 28, 1968</b> Hour <b>11:10 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 28, 1968</b> Hour <b>11:10 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>male</b>	7. RACE <b>white</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	E. STREET AND NUMBER <b>4011 Fourth Street</b>
9. DATE OF BIRTH <b>July 31, 1917</b>	10. AGE (In years lost birth day) <b>50</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Agent</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	
15. MOTHER'S MAIDEN NAME <b>Mary ---</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs. Rosalie Dabrowka - 4011 Fourth St.</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Warner U. Spitz, M.D.</b> DATE SIGNED <b>4/29/68</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5-1, 1968</b>	24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR <b>George J. Gonce</b>	25C. FUNERAL DIRECTOR ADDRESS <b>George J. Gonce-4001 Ritchie Hgwy., Baltimore</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>268-4647</u>
BIRTH NO. <u>517/68-4647</u>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>MARY DOWNNEY</u>		2. DATE AND HOUR OF DEATH <u>4-30-68 8:25 A.M.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 LAKE DRIVE NURSING HOME</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>		6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-86</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>BERNARD DOWNNEY</u>		14. MOTHER'S MAIDEN NAME <u>ELIZ KEEFING</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>2165-3150</u>	17. INFORMANT <u>LEONARD DOWNNEY</u> ADDRESS <u>ABOVE</u>	
18. <u>599.0 I</u>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>"shock"</u> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Gram Negative Bacteremia</u> DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>609X II</u>		(C) <u>Urinary Infection several decubiti</u>		
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Generalized Arteriosclerosis</u>		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1-20-1968</u> to <u>4-30-1968</u> , that (I) (we) last saw the deceased alive on <u>4-30-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Cesar Valle Cavero</u>			23B. DATE SIGNED <u>5-1-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO, M. D.</u>			23D. ADDRESS <u>8629 Liberty Road, Randallstown, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/2/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>GARDENS OF FAITH</u>
24D. LOCATION <u>BALTO. MD.</u>		24E. NAME OF REGISTRAR <u>Robert E. Fisher</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>J.D. CONNELLY SONS</u>
25D. ADDRESS <u>300 MACC</u>				

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68- 4648

BALTIMORE CITY HEALTH DEPARTMENT

68- 4648

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE E. GODWIN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 30, 1968</b> Hour <b>3:00 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>004537 Schenley Road</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 30, 1968 4:05 A.M.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>8/20/11</b>		10. AGE (In years last birthday) <b>57 56</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>IBM</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Md. Casualty Co.</b>	
15. MOTHER'S MAIDEN NAME <b>Elizabeth R. Jenkins</b>		E. STREET AND NUMBER <b>4537 Schenley Road</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		17. SOCIAL SECURITY NO. <b>212-10-3217</b>	
18. INFORMANT <b>J. Bernard Godwin</b>		ADDRESS <b>4537 Schenley Rd.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>4/22/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/30/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/3/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
25C. FUNERAL DIRECTOR <b>Austin E. Donovan</b>		ADDRESS <b>3818 Roland Ave.</b>	

William F. Gorman

Elizabeth H. Gorman

James H. Gorman

WALLACE F. GORMAN



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-200 68- 4649 BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 68- 4649	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <b>ROSS, JACQUELINE</b>		2. DATE AND HOUR OF DEATH <b>MAY 2, 1968</b> <span style="float: right;">1:02A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVENUES BALTIMORE, MARYLAND 21229</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21230</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1906 CASADEL AVENUE</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>05/25/25</b>
9. AGE (In years lost birthday) <b>45</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITRESS</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN CAKE</b>	
14. MOTHER'S MAIDEN NAME <b>MABEL SMALLWOOD</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>218-01-8261</b>		17. INFORMANT <b>ST AGNES HOSPITAL RECORDS</b>	
18. ADDRESS <b>CATON &amp; WILKENS AVES</b>		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1B. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic ca. to brain</i> <i>Squamous cell C.C. of large bowel</i> <i>intestinal obstructions</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....			
2. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>153.8 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 12</b> 19 <b>68</b> to <b>MAY 2</b> 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MAY 2</b> 19 <b>68</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>H. Mehdizadeh</i>		23B. DATE SIGNED <b>05/02/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. MEHDIZADEH</b>		23D. ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVES</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>	
25C. FUNERAL DIRECTOR <i>McCully F.H.</i>		25D. ADDRESS <b>237 Patapsco Ave. Balto. Md.</b>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 4650

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EMMA VOWELLS <i>Cross</i></b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>5 1 68 6:30 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>717 N. Rosedale St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 1 1968 6:30 a.m.</b>	
6. SEX <b>Female</b>		7. RACE <b>Colored</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>March 24/12</b>		10. AGE (In years lost birthday) <b>56</b>	
11. BIRTHPLACE (State or foreign country) <b>Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Jennings</b>		14. MOTHER'S MAIDEN NAME <b>Mary Molloy</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		16. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>None</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>412.4 I</b>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>422.1 II</b>		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>None</b>	
22A. DATE OF OPERATION <b>2</b>		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	
22E. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>None</b>		22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>	
ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-4-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>Clay Wilson</b>		25D. ADDRESS <b>1000 Brantley Ave</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4651

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 4651

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Joseph E. Neathery		4/29/68 12:45P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital				A. STATE MD B. COUNTY Balto	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Balto D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3304 St. Ambrose Ave, Balto 15	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-2-1906	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, oslenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction - with vent. fib. & pulmonary embolism		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF: Extension of Myo infarction - 16 hrs ->		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) ASCVD		
420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Periph vascular disease		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/29-11AM 19 68 to 4/30 midnight 19 68, that (I) (we) last saw the deceased alive on 4/29-1145AM 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A S Glushakov				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) A S GLUSHAKOV				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 5-3-1968	
24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery, Woodlawn, Balto Co, Md.				24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 3 1968		Robert E. Johnson		Spring Byers 8728 Liberty Road, Randallstown, Md.	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4652

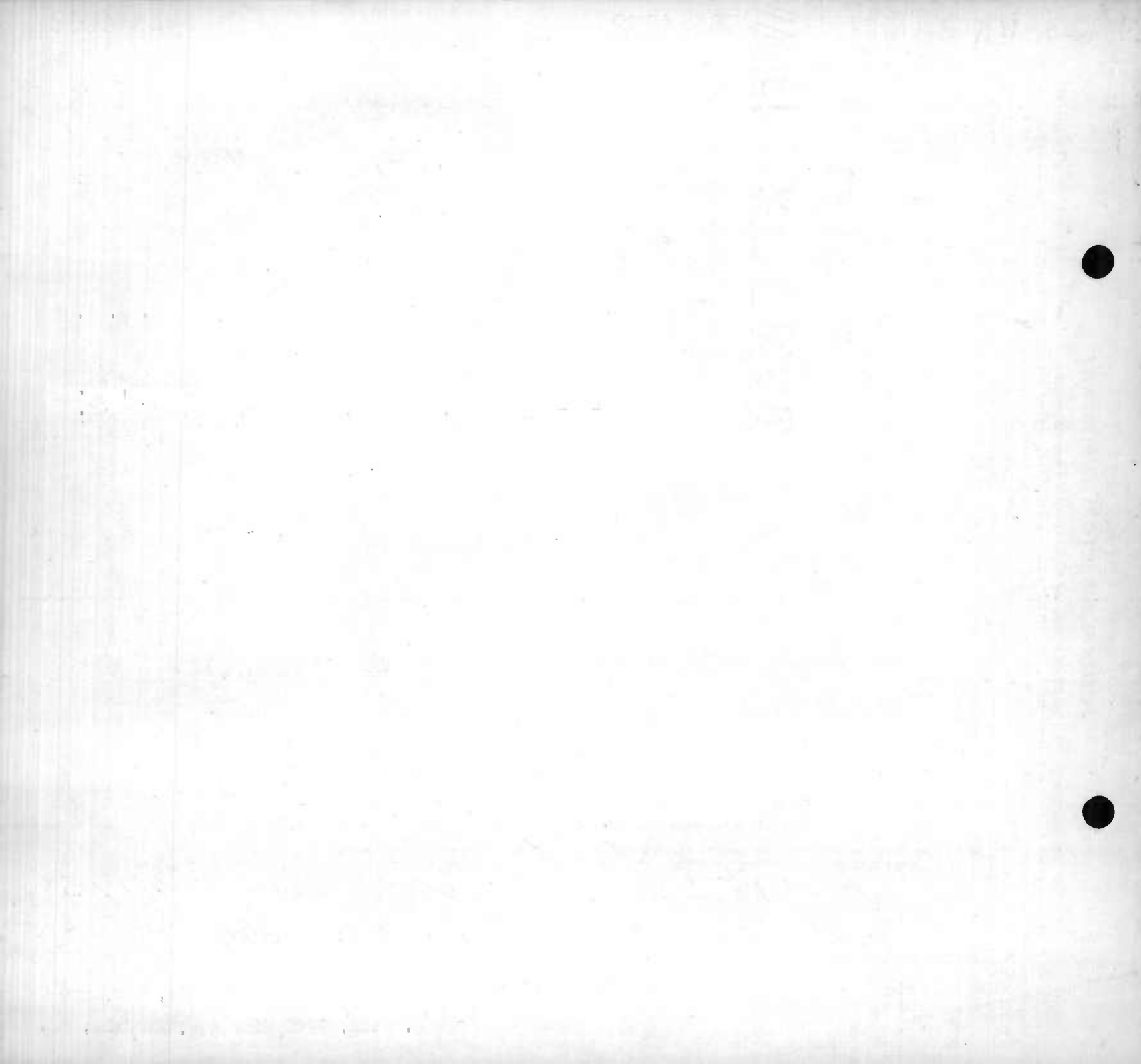
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68-4652

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Williams, Clarence G.</i>		2. DATE AND HOUR OF DEATH <i>4/30/68</i> <i>3 40 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1 Baltimore</i> 21219	
FULL NAME OF HOSPITAL OR INSTITUTION <i>49 NORTH CHARLES GENERAL HOSPITAL BALTIMORE MD.</i>				C. CITY <i>Edgemere</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>2917 Wells Road.</i> <i>53-00</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-6-05</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Owens Plastics</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
13. FATHER'S NAME <i>George Williams</i>				14. MOTHER'S MAIDEN NAME <i>Daisy Derrick</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>202-10-2875</i>		17. INFORMANT (Wife) <i>Edgemere, Md.</i> <i>Mrs. Helen L. Williams, 2917 Wells Rd.</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Myocardial Infarction</i> <i>sudden</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Chronic Coronary Artery Disease</i> <i>3 years</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19. <i>420.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>4/30</i> 19 <i>68</i> to <i>4/30/68</i> 19 <i>68</i> , that (1) (we) last saw the deceased alive on <i>4/30</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jose Martinez</i>				23B. DATE SIGNED <i>4/30/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOSE MARTINEZ</i>				23D. ADDRESS <i>Medical Arts Bldg MD 21201</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/3/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Bel Air Memorial Gardens</i>	
24D. LOCATION <i>Bel Air, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>John J. Duda, 7922 Wise Ave. Dundalk, Md.</i>			





# FUNERAL DIRECTOR: IMPORTANT

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68- 4653

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 4653

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Sarah A. Huebner

2. DATE AND HOUR OF DEATH

April 30, 1968

12:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90 Harford Gardens Nursing Home  
4700 Harford Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

8233 Peach Orchard Road

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Nov. 11, 1879

9. AGE (In years last birthday)

88

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Edwards

14. MOTHER'S MAIDEN NAME

Laura Burke

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-14-7985F2

17. INFORMANT

(Daughter

Dundalk, Md.

Mrs. Selma P. Gardner, 8233 Peach Orchard Rd.

18.

412.4 I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Antoniardentio Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5 years

422.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Duodend Ulcer

1 month

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If In Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1967 to April 1968, that (I) (~~we~~) last saw the deceased alive on Apr. 129.19 68 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (~~did not~~) view the body after death.

23A. SIGNATURE

Loy M. Zimmerman M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

5/1/68

23C. PHYSICIAN'S NAME (Type)

Loy M. Zimmerman

M.D.

23D. ADDRESS

3202 Harford Rd. Baltimore, Md. 21213

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5/3/68

24C. NAME of CEMETERY or CREMATORY

Mt. Olivet Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAY 3 1968

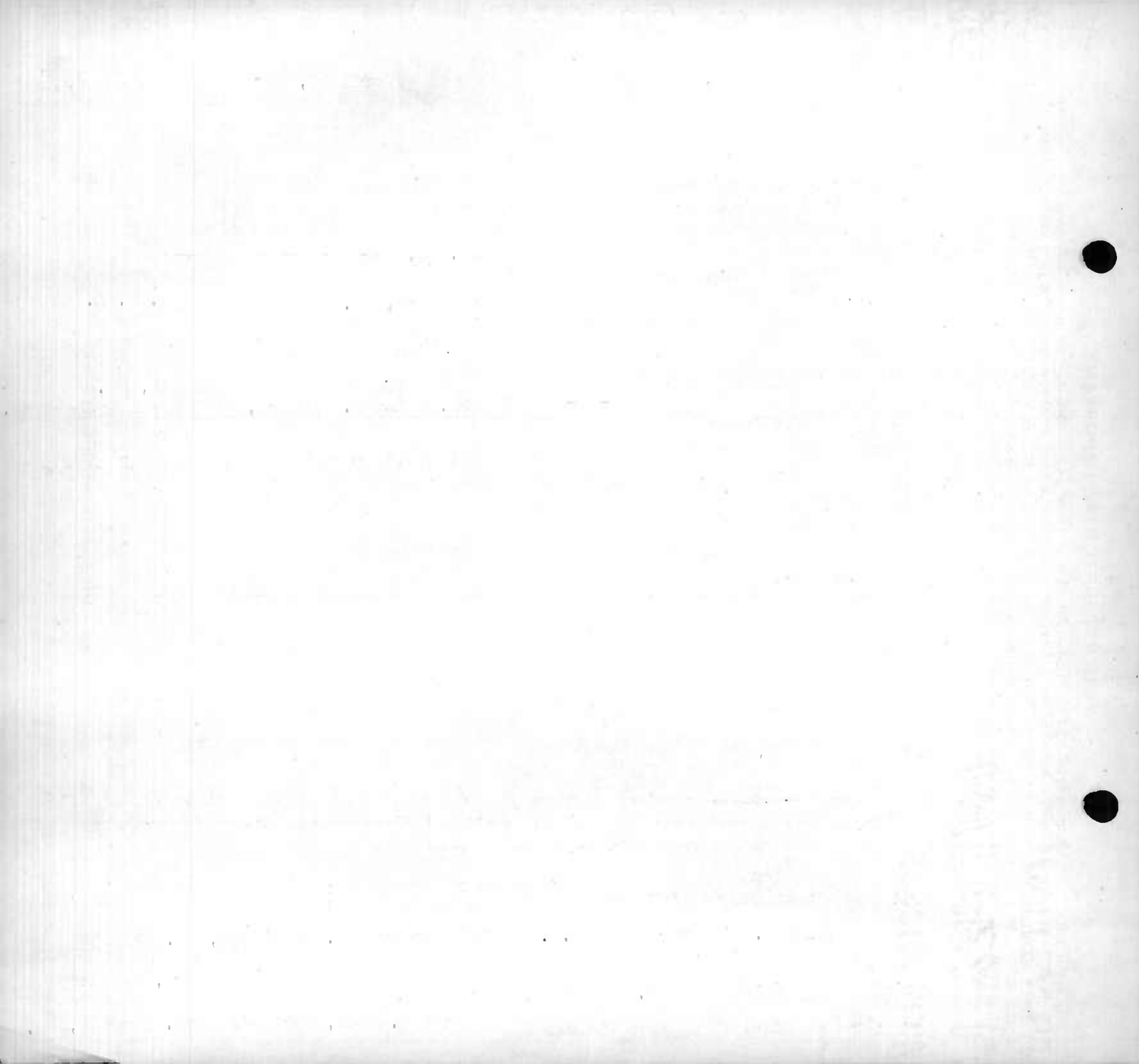
25B. NAME OF REGISTRAR

Robert E. Farkas

25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
		HOHLBEIN, EDWARD EARL		MAY 1, 1968		2:25 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  40 ST AGNES HOSPITAL				A. STATE MARYLAND		B. COUNTY 21227	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 4016 HICKORY AVENUE			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 09/17/06	
				9. AGE (In years last birthday) 61		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equip Operator				10B. KIND OF BUSINESS OR INDUSTRY Balto Co		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME JOHN HOHLBEIN				14. MOTHER'S MAIDEN NAME Anna Hines			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST AGNES RECORDS-WILKENS & CATON AVES	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 410.9 I Myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Pre-existing hypoxia and coronary DUE TO, OR AS A CONSEQUENCE OF: (C) Heart disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from APRIL 28, 1968 to MAY 1, 1968, that (X) (we) last saw the deceased alive on MAY 1, 1968 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George R. Angov				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) GEORGE R. ANGOV				23D. ADDRESS ST AGNES HOSPITAL-CATON & WILKENS AVE BALTO MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/68		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) AA Co Md	
25A. DATE RECEIVED BY HEALTH DEPT. MAY 3 1968		25B. NAME OF REGISTRAR Robert E. Fickens		25C. FUNERAL DIRECTOR McCully Funeral Home		25D. ADDRESS 237 Patapsco Ave	

ST. LOUIS  
1914  
17. 10000 AVENUE

WHITE  
MAY 1914

10000 AVENUE

ST. LOUIS  
MAY 1914

MAY 1914

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4655	
S-363 68-4655		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH M. STEWART</b>		2. DATE AND HOUR OF DEATH <b>4-30-68 8:59 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSP</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>-</b> C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>923 N. GILMORE ST.</b>			
5. SEX <b>F</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-13-01</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212163568D</b>		17. INFORMANT <b>MRS. RAYMOND BARBER</b> ADDRESS <b>1116 N. CALHOUN ST.</b>	
18. <b>731.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Infarcted Hge CVA</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ventricular invasion</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD and Hermafin</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>331X II</b>		20A. AUTOPSY (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 30 1968</b> to <b>April 30 1968</b> , that (I) (we) last saw the deceased alive on <b>April 30 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Enrique Cipriani M.D.</b>		23B. DATE SIGNED <b>4/30/68</b>		23C. PHYSICIAN'S NAME (Type) <b>ENRIQUE CIPRIANI M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-3-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>		25C. FUNERAL DIRECTOR <b>Kelson Funeral Home 1348 Calhoun St.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. LOCATION (State) <b>Baltimore, Maryland</b>			

223 N CHANCE ST  
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112 112 112

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April 30 08  
April 30 08

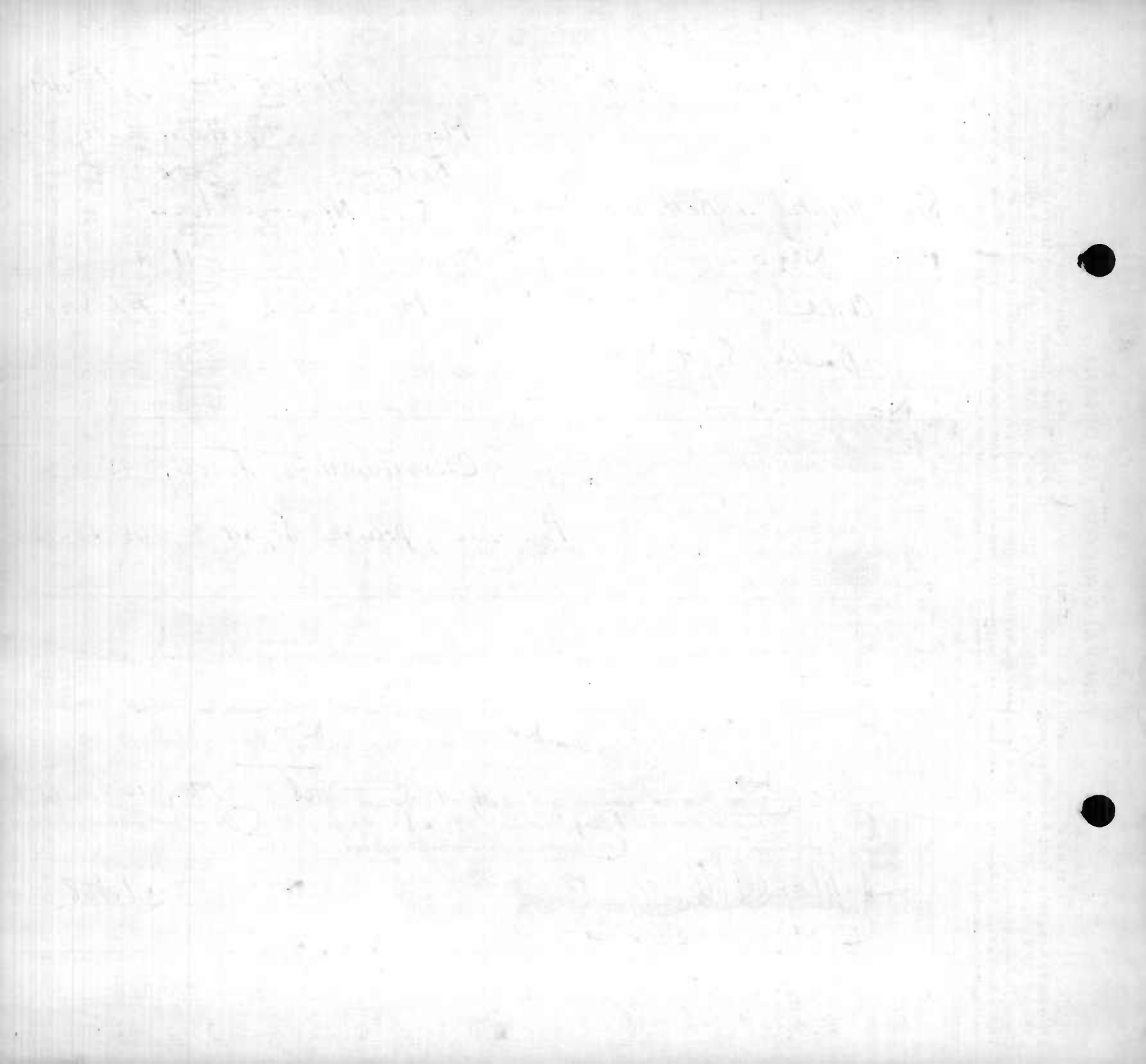
ENGINE SPINNING  
ENRIDGE CIRCUIT M.B. 33 and COAST



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

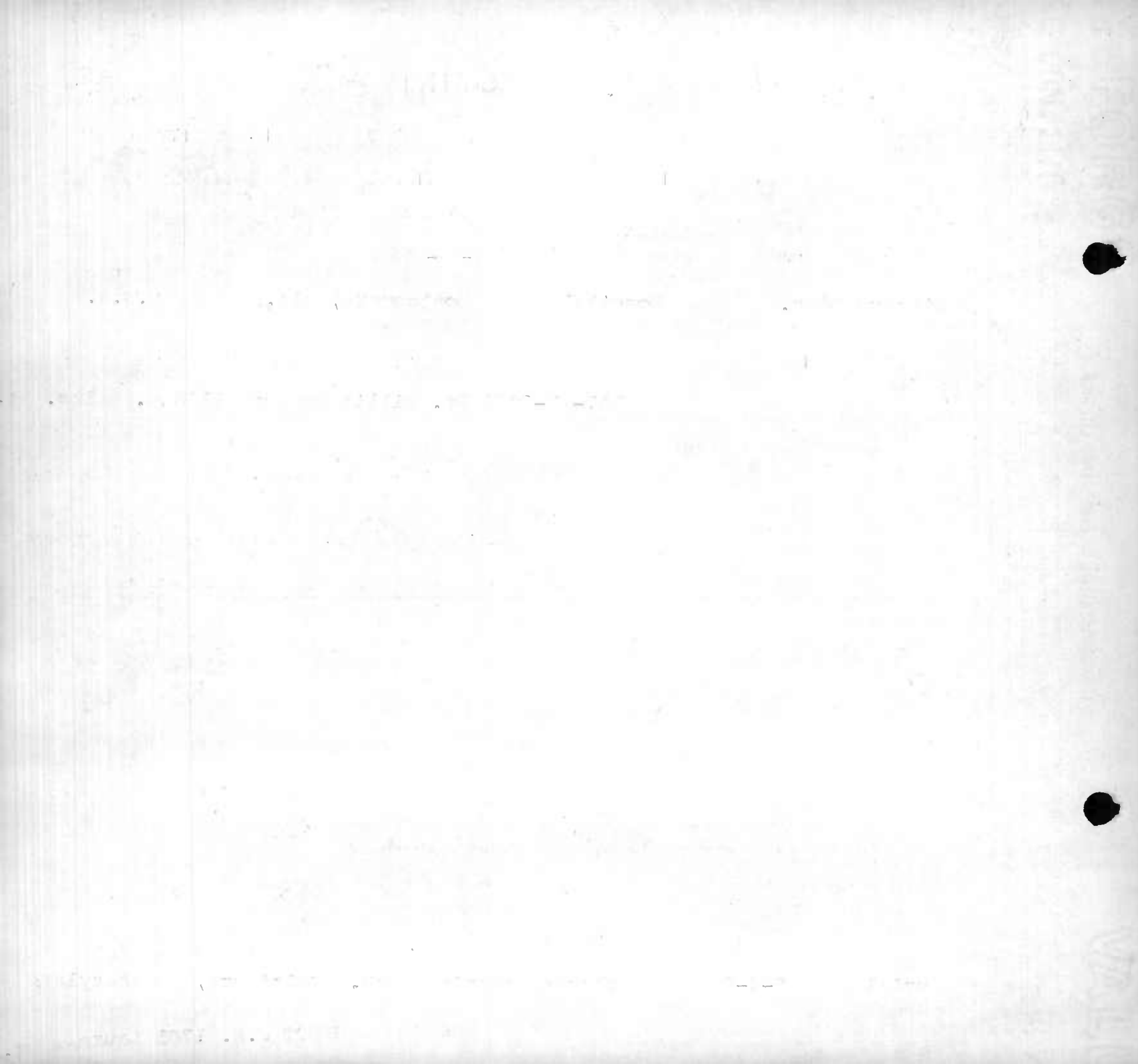
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4656	
<div style="display: flex; justify-content: space-between;"> <span>5-300</span> <span>68-4656</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO. 67-09947		1. NAME OF DECEASED (Type or Print) Donald Scott Sr.		2. DATE AND HOUR OF DEATH MAY 1 1968 1:35 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinner Hospital at Baltimore Inc.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5002 Norwood Ave.		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21 1967	9. AGE (In years last birthday) 11 9	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Donald Scott Sr.			14. MOTHER'S MAIDEN NAME Mary Dorsey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Donald Scott Sr. 5002 Norwood Ave.	
<div style="display: flex;"> <div style="flex: 1;"> <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory Arrest - 45 min</p> <p>(B) PNEUMONIA, POSSIBLE SEPSIS DUE TO, OR AS A CONSEQUENCE OF: 48 hours</p> <p>(C) _____</p> </div> <div style="flex: 0.5;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
<p>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> <p>19A. DATE OF OPERATION 2</p> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>19C. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No</p> <p>19D. TIME OF INJURY (Month) (Day) (Year) (Hour) No</p> <p>20A. AUTOPSY? (Yes or No) Yes</p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No</p> <p>21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No</p> <p>21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No</p> <p>21C. HOW DID INJURY OCCUR?</p> <p>21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>					
<p>22. I certify that (I) (this hospital) attended the deceased from April 30 19 68 to May 1 19 68, that (I) (we) last saw the deceased alive on May 1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>					
23A. SIGNATURE I. Meyer Heller M.D.			23B. DATE SIGNED 5/1/68		23C. PHYSICIAN'S NAME (Type) I. Meyer Heller M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 5-4-68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery
24D. LOCATION (City, town, or county) Baltimore, Maryland			24E. DATE REC'D BY HEALTH DEPT. MAY 3 1968		
24F. NAME OF REGISTRAR Robert E. Farber			24G. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-330		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4657	
1. NAME OF DECEASED (Type or Print) <b>Mary L. Reader (Smith)</b>		2. DATE AND HOUR OF DEATH <b>May 1, 1968 1 45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>41 WHEELER AVENUE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-30-28</b>	9. AGE (In years last birthday) <b>39</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dietary Dept.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Montgomery, Ala.</b>	
13. FATHER'S NAME <b>GEORGE SMITH</b>		14. MOTHER'S MAIDEN NAME <b>EUGIRTHA OWENS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-22-3969</b>		17. INFORMANT <b>Mr. Willie Reader</b> ADDRESS <b>2118 W. Balto. St.</b>	
18. <b>734.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Nephritis</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Nephritis</b> (B) <b>Systemic Lupus Erythematosus 10 years</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>436X II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(this hospital)</b> attended the deceased from <b>3/30</b> 19 <b>68</b> to <b>5/1</b> 19 <b>68</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>5/1</b> 19 <b>68</b> and that <b>(my)</b> (our) opinion of death occurred on the date and hour and from the causes stated above <b>(I)</b> (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Albert B. Einstein, Jr., M.D.</b>		23B. DATE SIGNED <b>5/1/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Albert B. Einstein, Jr., M.D.</b>	
23D. ADDRESS <b>Johns Hopkins Hospital</b>		24. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>5-4-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park.</b>		24D. LOCATION (City, town, or County) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b> ADDRESS <b>1701 Laurens St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4658

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68-4658

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>(Willie) WILLIA MAE GLENCAMP (Glenycamp)</b>		2. DATE AND HOUR OF DEATH <b>April 30, 1968</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>39 PROVIDENT HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1104 Laurens Street</b>		
5. SEX <b>F.</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-28-1916</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Granit Quarry, N.C.</b>	
13. FATHER'S NAME <b>JOHN KERNS</b>			14. MOTHER'S MAIDEN NAME <b>QUEENER KERNS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Fred Glencamp</b> ADDRESS <b>1104 Laurens</b>	
18. <b>200091</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Diabetes</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes</b> (B) <b>Arteriosclerotic C.V. Disease</b> (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>260X II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-16-1962</b> to <b>4-30-1968</b> , that (I) (we) lost saw the deceased alive on <b>2-15-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Maurice L. Adams</b> DEGREE				23B. DATE SIGNED <b>5-2-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MAURICE L. ADAMS</b> DEGREE				23D. ADDRESS <b>238 N. Cary St. Balt. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-4-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Carver Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley, MA</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b> ADDRESS <b>1701 Laurens St.</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4659

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 798-4659

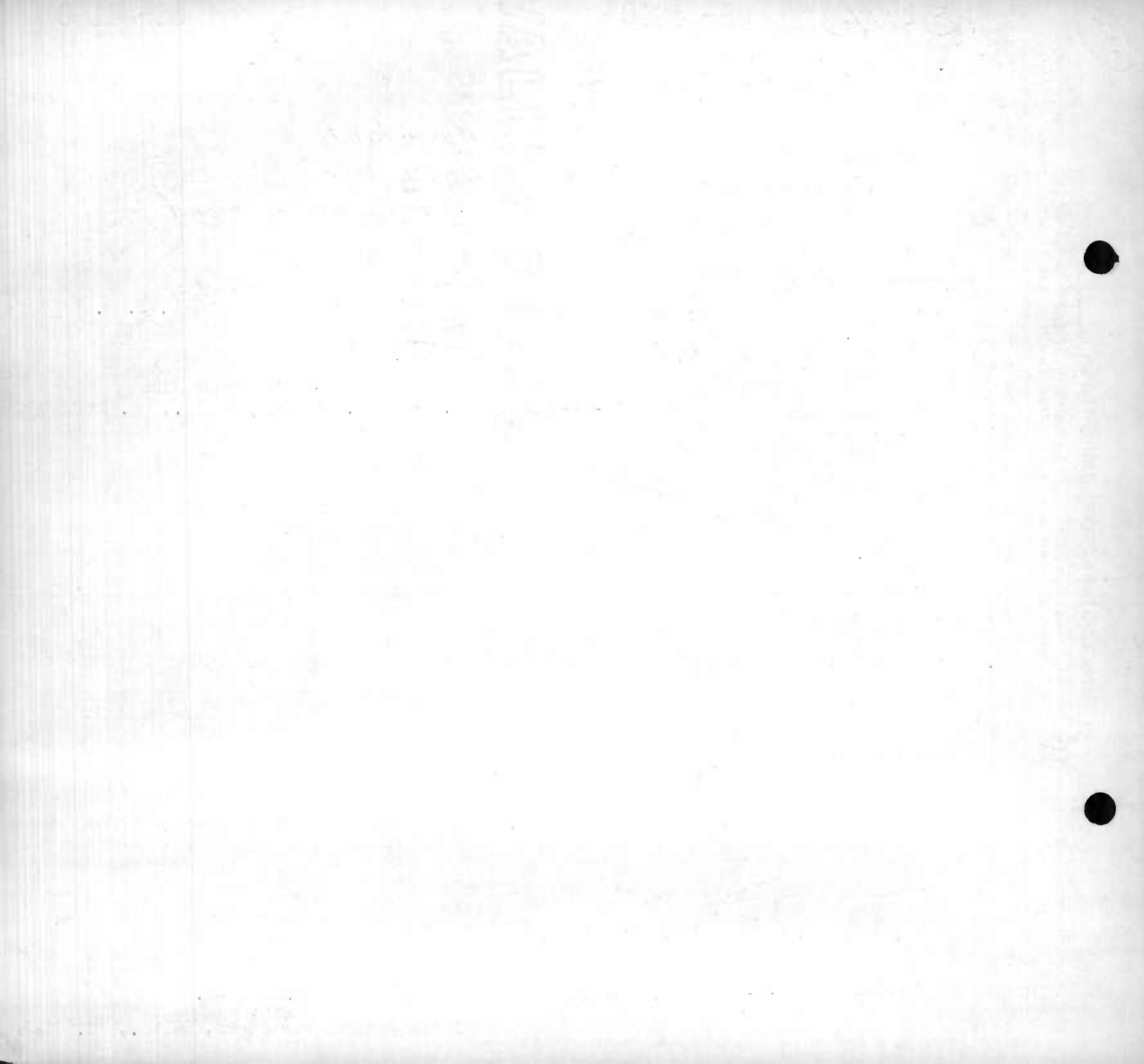
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Adelaide Hawkins</i>		2. DATE AND HOUR OF DEATH <i>4/23/68 10:45 AM</i>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>607 Pennsylvania Ave. Carter Comm. Home</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? <i>Yes</i> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1846 N. Saratoga Street</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/28/89</i>	9. AGE (In years last birthday) <i>76 yrs.</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Practical Nurse</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Beverly Seward</i>				14. MOTHER'S MAIDEN NAME <i>Amadia <del>H</del> Seward Virginia</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>219-30-9364</i>		17. INFORMANT <i>C Hart</i>			
18. <i>412.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Hemorrhage</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
				(B) <i>Hypertensive Card.-Vas. Disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Unknown</i>			
				(C) <i>Post CVA</i>		<i>Unknown</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>443X II</i>				<i>Dissection of H. p. Left</i>			
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7/22</i> 19 <i>66</i> to <i>4/23</i> 19 <i>68</i> . that (I) (we) lost saw the deceased alive on <i>4/23</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>E. E. Holt M.D.</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4/25/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. E. Holt M.D.</i>				23D. ADDRESS <i>3715 Liberty Heights Ave. Baltimore Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/27/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MA. Culverly Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairley</i>		25C. FUNERAL DIRECTOR <i>John Russell 1712 W. North Ave</i>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-140		68-4660		BALTIMORE CITY HEALTH DEPT.		REG. NO. 68-4660	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) <i>Shipley Louis C.</i>				2. DATE AND HOUR OF DEATH <i>May 1, 1968</i> 10:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Bolton Co. 53-00</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hosp.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> 21229		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-14-99</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>State Bank Examiner</i>		9. AGE (In years last birthday) <i>68</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Harvey Shipley</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>218-36-9442 A</i>		17. INFORMANT <i>Mrs. Louis G. Shipley, Balto., Md. 21229</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF: <i>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION <i>422.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>March 31</i> 19 <i>68</i> to <i>May 1</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>May 1</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Adrian V. Villarín</i>				23B. DATE SIGNED <i>May 1, 1968</i>		23C. PHYSICIAN'S NAME (Type) <i>ADRIAN V. VILLARIN</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-4-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Springfield</i>		24D. LOCATION (City, town, or county) (State) <i>Sykesville, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Witzke Funeral Directors, Balto., Md. 21229</i>		ADDRESS <i>4101 Edmondson Avenue</i>	



B-530 68-4661

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-4661

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FRANK BENNETT</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>April 29, 1968 10:15 P.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 29, 1968 10:15 P.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>11/27/35</b>		10. AGE (In years lost birthday) <b>32</b>	
11. BIRTHPLACE (State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>216-30-7519</b>	
15. MOTHER'S MAIDEN NAME <b>Essie Bennett</b>		18. INFORMANT <b>Dora Nance</b>	
19. CAUSE OF DEATH <b>Fatty Alteration of Liver</b>		ADDRESS <b>1643 N. Monroe Street</b>	
20A. DATE OF OPERATION <b>5-7-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>5-8-68 11</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) <b>Yes</b>	
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>4/30/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/4/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E. North Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
L-600		68-4662		68-4662	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LEARY, NELSON		4.29.68		8:40 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  LUTHERAN HOSPITAL OF MARYLAND 46			A. STATE MD		
			B. COUNTY		
5. SEX M			6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-28-97
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 71
13. FATHER'S NAME			11. BIRTHPLACE (State or foreign country) N.C.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?
			17. INFORMANT CHART		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Progressive cerebral Thrombosis (B) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION 2			20A. AUTOPSY? (Yes or No) YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Approx.)			21E. INJURY OCCURRED		
21F. HOW DID INJURY OCCUR?			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 4.15.68 to 4.29.1968, that (I) (we) last saw the deceased alive on 4.29.1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Aziz			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) S. Aziz			23D. ADDRESS LUTHERAN HOSPITAL OF MD, BALTO, MD 21216		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/3/68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Betha Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 3 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR Wm C. March		25D. ADDRESS 928 E. North			

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1-28-91 11

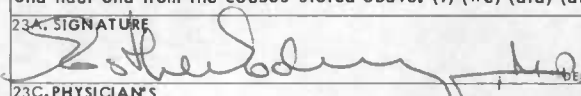
CHART  
Largest area of water  
within outer harbor

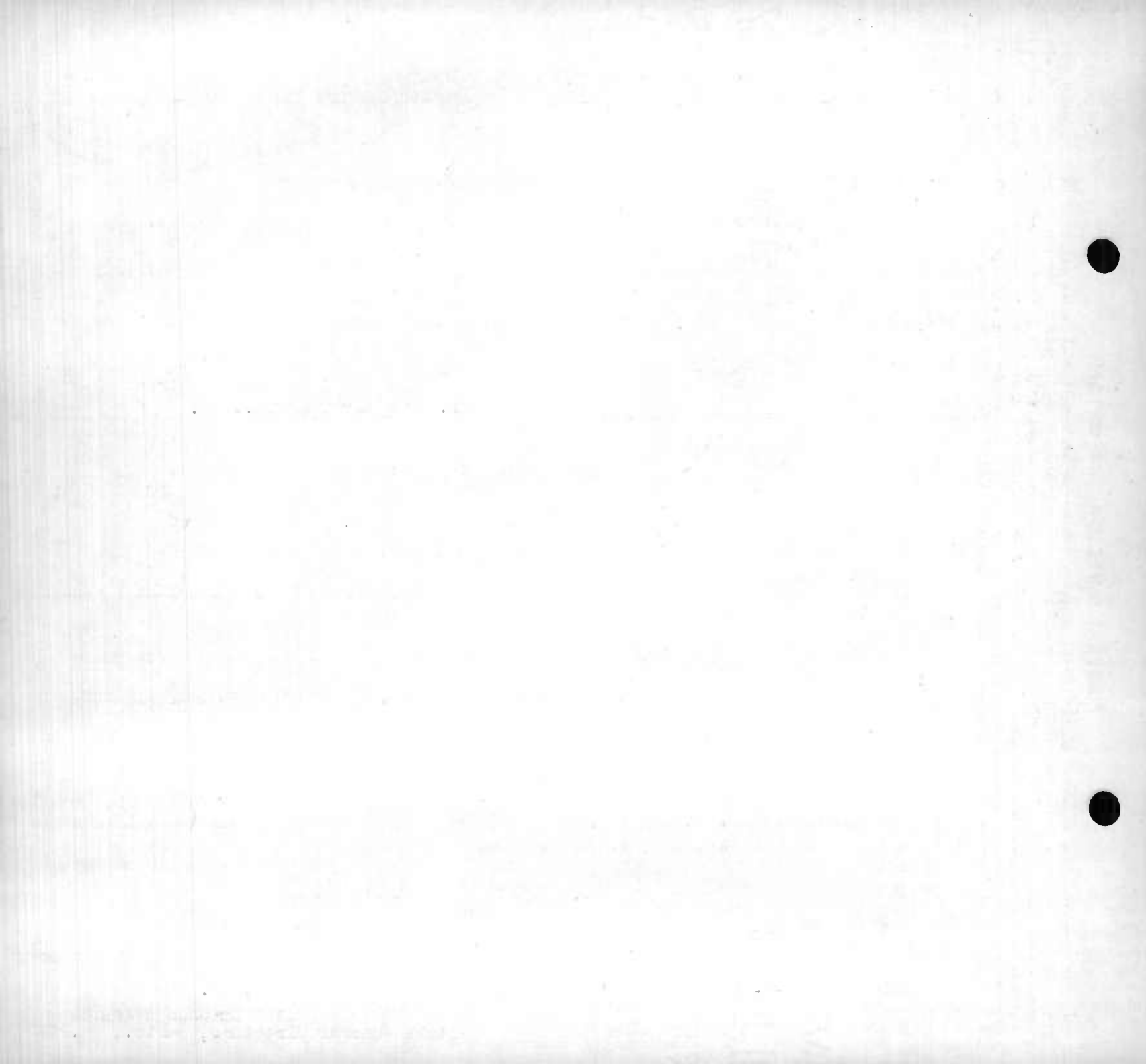
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

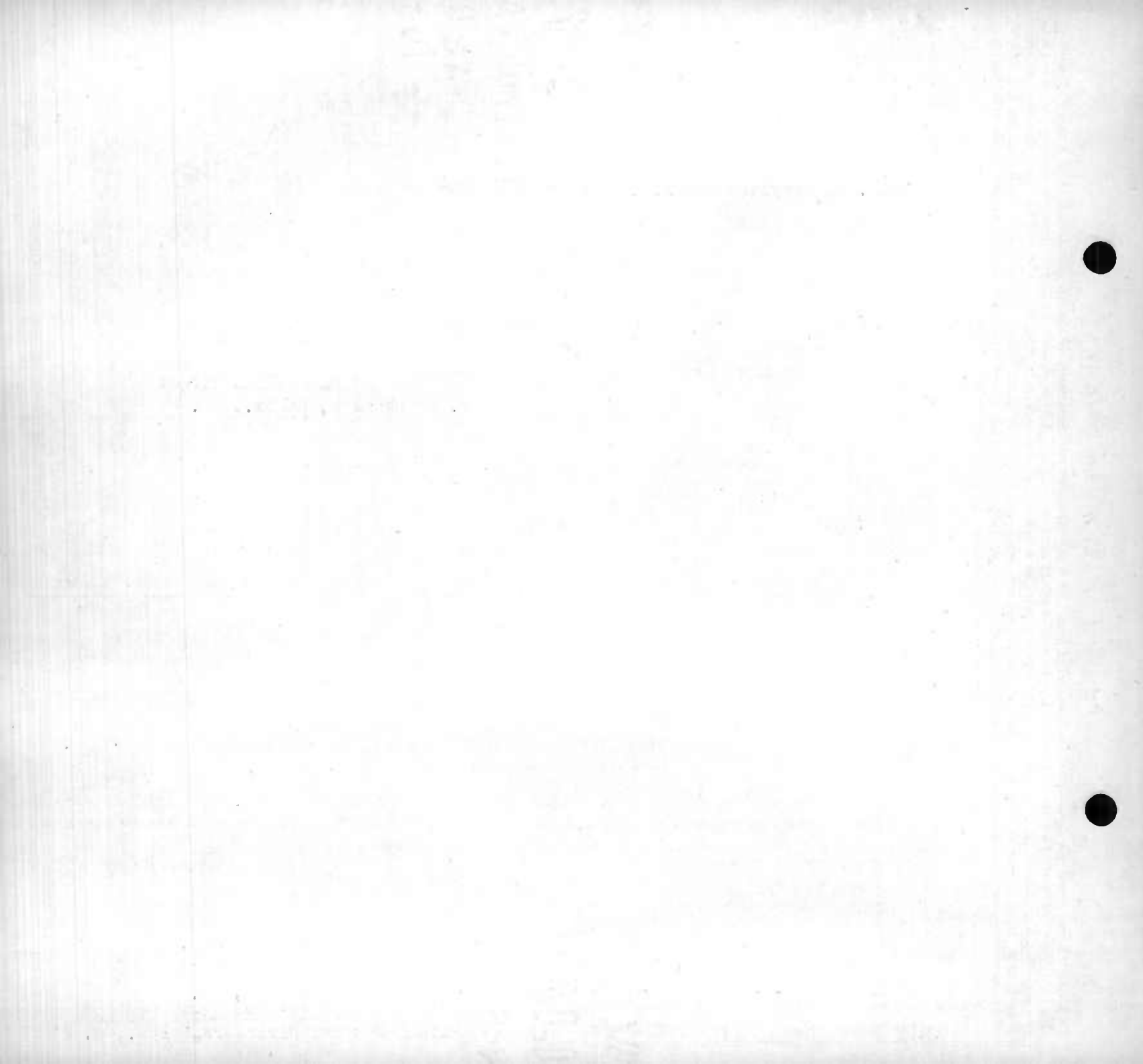
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4663</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>C-462</b></span> <span><b>68-4663</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO. <b>68-08202</b>		1. NAME OF DECEASED (Type or Print) <b>BABY GIRL CHARL (B)</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <b>April 30, 1968</b>   <b>2:10 P.M.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. OF MARYLAND HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		E. STREET AND NUMBER <b>1608 HOLLINS ST.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 29, 1968</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days:   If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>FRANK E. CHARK</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA LEASE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Frak Clark, Balto., Md.</b>	
18. <b>769.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY DISTRESS</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PREMATURITY</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. <b>773.5 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 29 1968</b> to <b>April 30 1968</b> , that (I) (we) last saw the deceased alive on <b>April 30 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED <b>4/30/68</b>		23C. PHYSICIAN'S NAME (Type) <b>ESTHER EDERLY M.D.</b>	
23D. ADDRESS <b>UNIV. OF MARYLAND HOSPITAL-BALTO</b>		24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>5-2-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lease's Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Witzke Funeral Directors, Balto., Md. 21229</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-4664</u>	
<div style="display: flex; justify-content: space-between;"> <span>C-462</span> <span>68-08201 68-4664</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print) <u>BOBY BOY CLARK (A)</u>			2. DATE AND HOUR OF DEATH <u>April 30, 1968 19:25 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>Univ. of Maryland Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1608 HOLLINS ST.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 29, 1968</u>	9. AGE (In years last birthday) <u>20</u>	If Under 1 Yr. Months: <u>20</u> Days: <u>25</u> If Under 24 Hrs. Hours: <u>25</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>FRANK E. CLARK</u>			14. MOTHER'S MAIDEN NAME <u>BARBARA LEESE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>1608 Hollins Street</u> <u>Mr. Frank Clark, Balto., Md.</u>	
18. <u>776.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <u>RESPIRATORY DISTRESS</u> (A) IMMEDIATE CAUSE <u>PREMATURITY</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>PREMATURITY</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>773.5-II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 29 1968</u> to <u>April 30 1968</u> , that (I) (we) last saw the deceased alive on <u>April 30 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Esther Ebery M.D.</u> DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>ESTHER EBERY M.D.</u>				23D. ADDRESS <u>UNIV. OF MARYLAND HOSP. - BALTO</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-2-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lease's Cemetery</u>	
24D. LOCATION <u>Cumberland, Md.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>4101 Edmondson Avenue</u> <u>Witzke Funeral Directors, Balto., Md. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4665	
<div style="display: flex; justify-content: space-between;"> <span>2-520</span> <span>68-4665</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		A. <b>Clarence Lomax</b>		4-30-68 7:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital, Inc.</b>			A. STATE <b>Maryland</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore,</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>859 Harlem Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-26-08</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <b>Sarah Lomax</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Joan Lomax - daughter 221 Beal Court</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>269.9 I</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Malnutrition, Dehydration</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>286.5 II</b>			<b>Pyelonephritis, Acute, Abdominal</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>xxx yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 26, 1968</b> to <b>April 30, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 30, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Humbert Certaza</b>				23B. DATE SIGNED <b>4-30-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Certaza</b>				23D. ADDRESS <b>M.D. 1514 Division Street Balto., Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/4/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm C March 928 E. North Ave.</b>	

Philadelphia, Pa.

Philadelphia, Pa.

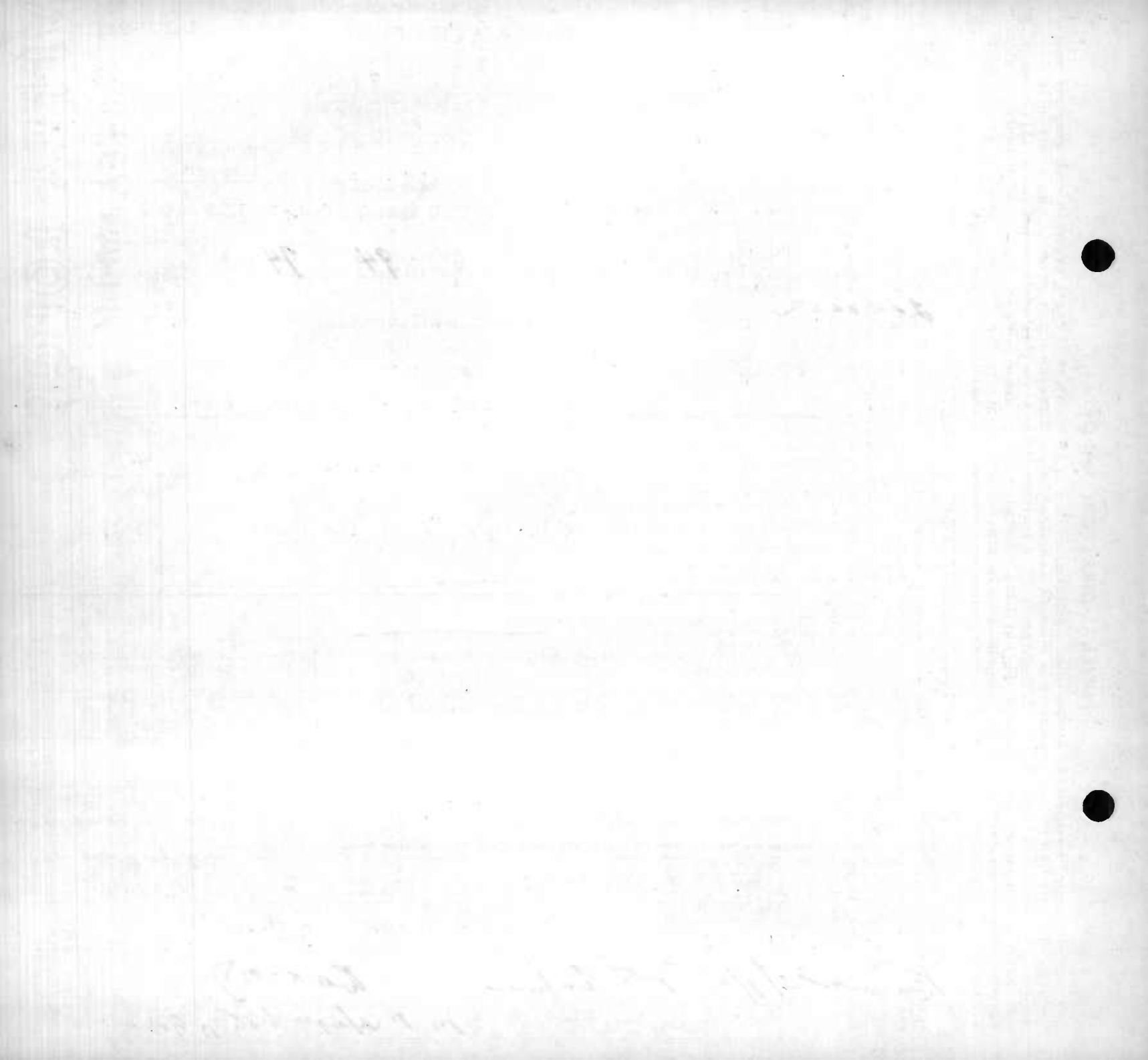
Philadelphia, Pa.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68-4666</b>	
BIRTH NO. <b>68-4666</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Morris, William W.</b>		2. DATE AND HOUR OF DEATH <b>April 30 1968 2:25 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>26-12</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b># 21224</b> <b>Baltimore City Hospital's</b> <b>4940 Eastern Ave. Baltimore, Maryland</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b> 6. RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/30/94</b> 9. AGE (In years lost birthday) <b>74 yrs</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Morris Sr.</b>		14. MOTHER'S MAIDEN NAME <b>MARY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>13-099181</b> 17. INFORMANT <b>BCH: Records 4940 Eastern Ave. Baltimore, Md.</b>	
18. <b>440.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>+10 yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Multiple Severe Decubiti</b> DUE TO, OR AS A CONSEQUENCE OF: <b>1 year</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>4350.0 II</b>			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 1967</b> to <b>April 30 1968</b> , that (I) (we) last saw the deceased alive on <b>April 30 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Osis S. Al-Awqati M.B., Ch.B.</b> DEGREE <b>MD.</b> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>4/30/68</b>
23C. PHYSICIAN'S NAME (Type) <b>Osis S. Al-Awqati</b> DEGREE <b>MD.</b>			23D. ADDRESS <b>Baltimore City Hospital's 4940 Eastern Ave. Baltimore, Maryland #21224</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried 3/4/68</b>	24B. DATE	24C. NAME OF CEMETERY or CREMATORY <b>Mount Airy</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>M. R. Jones 636 N. G. ... St</b> ADDRESS	

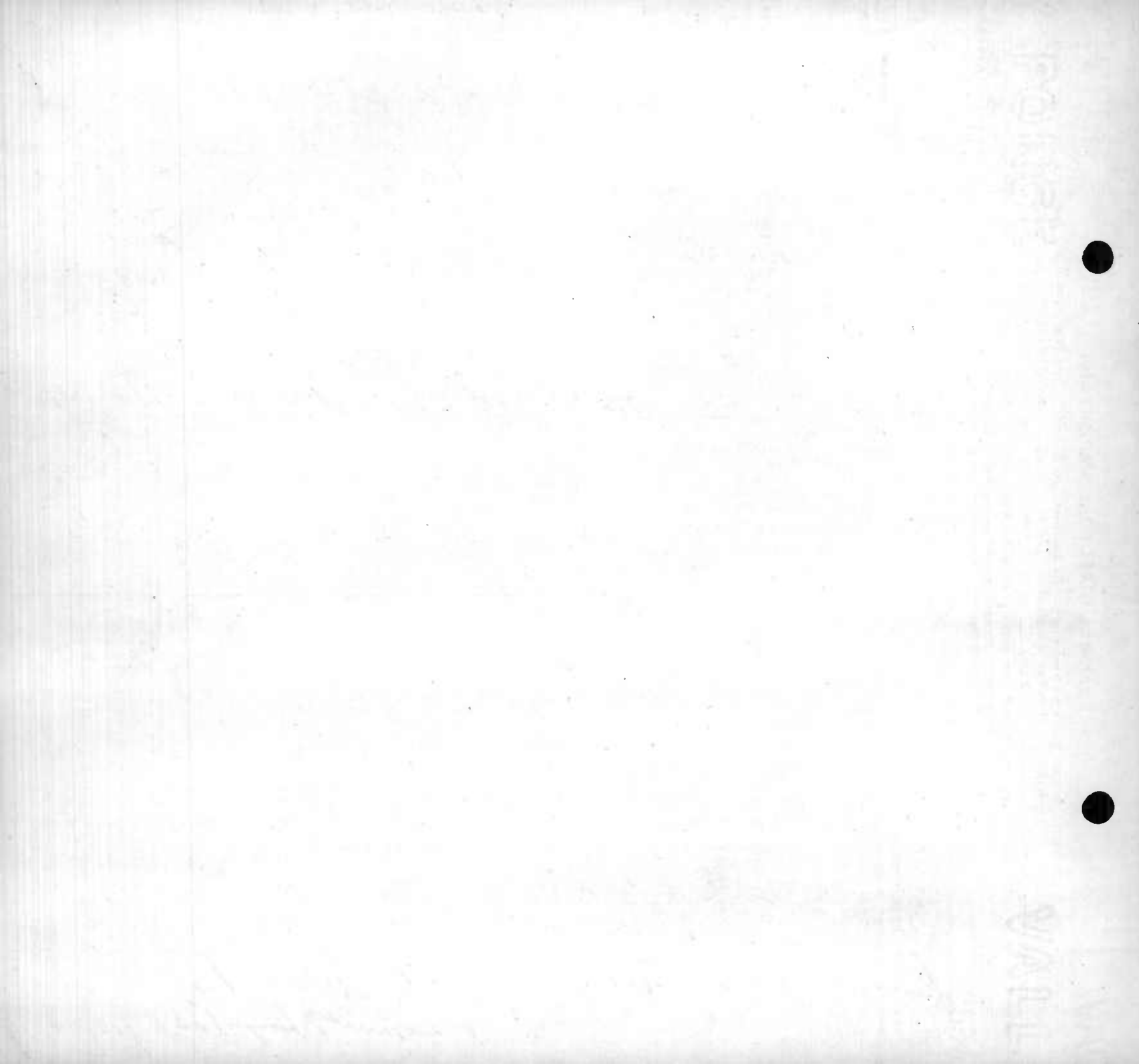




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4667	
68- 4667				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>William J. Hembry</u>		2. DATE AND HOUR OF DEATH <u>1 May 1968</u> <u>9 00 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>16-05</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Balto</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2311 Arunah Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/4/07</u>	9. AGE (In years lost birthday) <u>60</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>manual labor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>const.</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Sam Hembry</u>		14. MOTHER'S MAIDEN NAME <u>Martha Best</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>212-05-3325</u>		17. INFORMANT ADDRESS <u>Chart + Mrs Genal Hurby</u>	
18. <u>203 X I</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>		<u>2 wks</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>multiple myeloma</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>2 1/2 years</u>	
(C) _____					
203 X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> 19 <u>65</u> to <u>May</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1 May</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Francis D. Drake, M.D.</u>		23B. DATE SIGNED <u>1 May 68</u>		23C. PHYSICIAN'S NAME (Type) <u>Francis D. Drake, M.D.</u>	
23D. ADDRESS <u>University of Md. Hosp</u>		23E. FUNERAL DIRECTOR <u>Marshall W. Bays</u>		23F. ADDRESS <u>3809 G. Morris</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burned</u>		24B. DATE <u>5/6/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Park</u>	
24D. LOCATION <u>Arbutus Park</u>		24E. LOCATION (City, town, or county) <u>Baltimore</u>		24F. LOCATION (State) <u>MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Marshall W. Bays</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 4668

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CARL L. ROBERTS

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

(DOA)

South Baltimore General Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

May 1, 1968

10:15 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Feb. 28, 1958

10. AGE (In years  
last birthday)

10

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

901 Coppin Court

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Ebby Roberts

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary Lester

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

none

18. INFORMANT

ADDRESS

Mary Roberts 901 Coppin Court

19.

E 818.18

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Crushing injuries of head  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E 824.7 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A: DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Carver Road near Bridgeview Road

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

5-1-68 9:25 P.

22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject fell off  
side of bus - ran over by same

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 2, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

May 6, 1968

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Pk.

24D. LOCATION (City, town, or county)

Arbutus Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 3 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Woodch. St.

ADDRESS

WATKINS FORGE

10/14/1911

10:00

10:00

10:00

10:00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4669

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 4669

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOANNA WARMINSKI		MAY 2, 1968 11: A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 90 THE GOULD CONVALESCARIUM 6116 BELAIR RD.				A. STATE MD. B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 615 S. POTOMAC ST.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-94	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-6762	17. INFORMANT S WARMINSKI 5805 HAMILTON AVE.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebro-Vascular accident 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ASCVD				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 2 days 10 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 18, 1967 to May 1, 1968, that (I) (we) lost saw the deceased alive on May 1, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. W. Gardner				23B. DATE SIGNED 5/2/68	
23C. PHYSICIAN'S NAME (Type) J. W. Gardner				23D. ADDRESS Baltimore 21237	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6/68		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Wm. Fialkowski 2007 Eastern Ave.	

Plummer  
Cable-Recorder  
A 26 V D

W. H. Thompson  
Chief of Dept of  
Files 212



C-230

68-4670

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-4670

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

PIER L. COSTA OR PETER LOUIS

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

4

30XX

68

6:30 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

D.O.A.

Veteran's Hospital 3900 Loch Raven

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

April

30,

1968

6:30 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

Sept 20/66

10. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

18

E. STREET AND NUMBER

1303 Windemer Ave.

11. BIRTHPLACE (State or foreign country)

BALTO. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

PAUL COSTA

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

THERESA SANSONE

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

PAUL COSTA 1303 WINDEMER AVE

19. E911X1

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Asphyxia  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) aspiration of food  
DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E9212 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1303 Windemer Ave.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

4

30

68

?

m.

22E. INJURY OCCURRED  
WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject aspirated on food

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 1, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

5/4/68

24C. NAME OF CEMETERY or CREMATORY

CORRAINE PARK

24D. LOCATION (City, town, or county)

WOODLAWN.

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 3 1968

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

Frank Della Noce 322 St. High

ADDRESS

Section of road

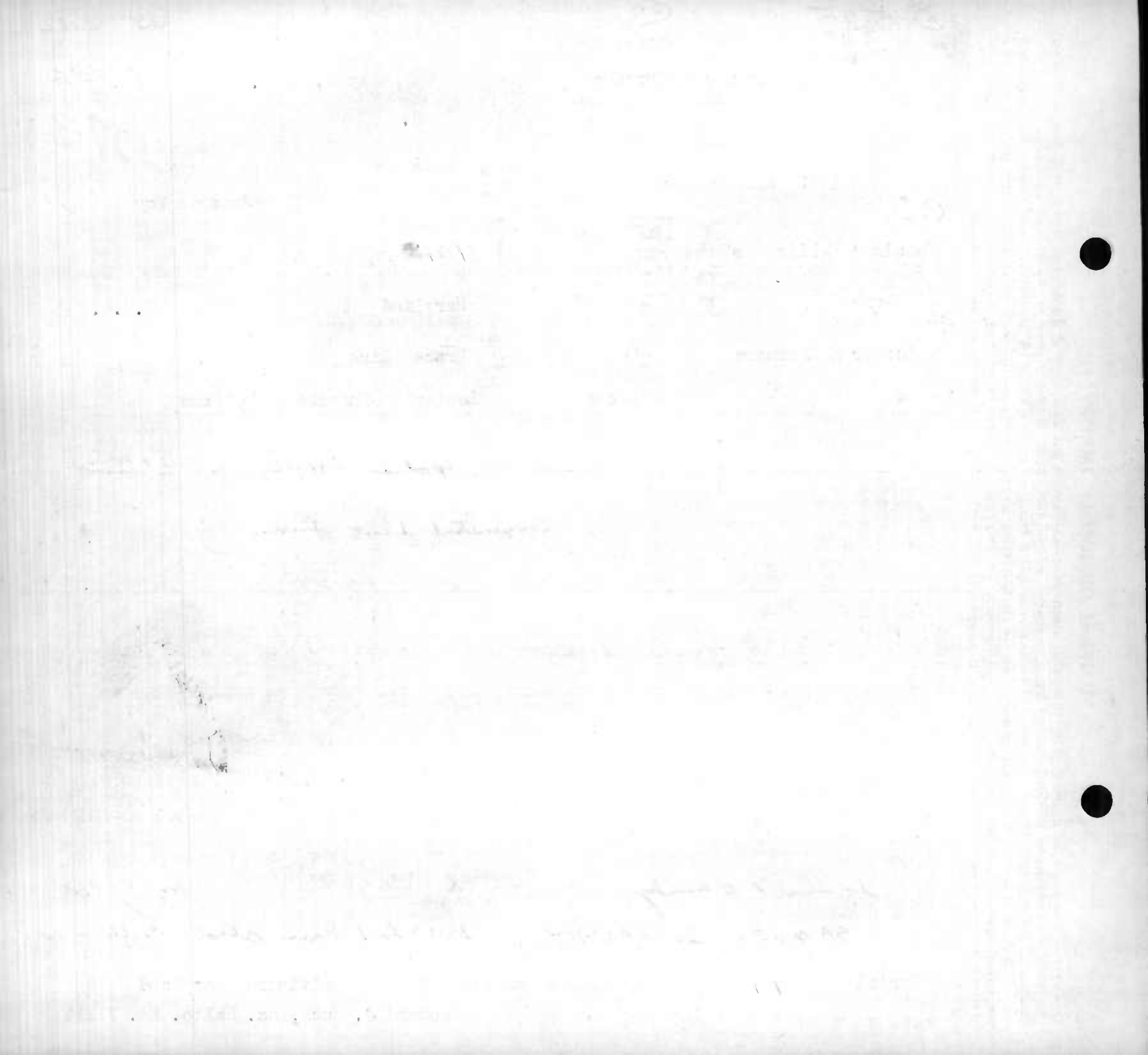
WATKINS

Still + water

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

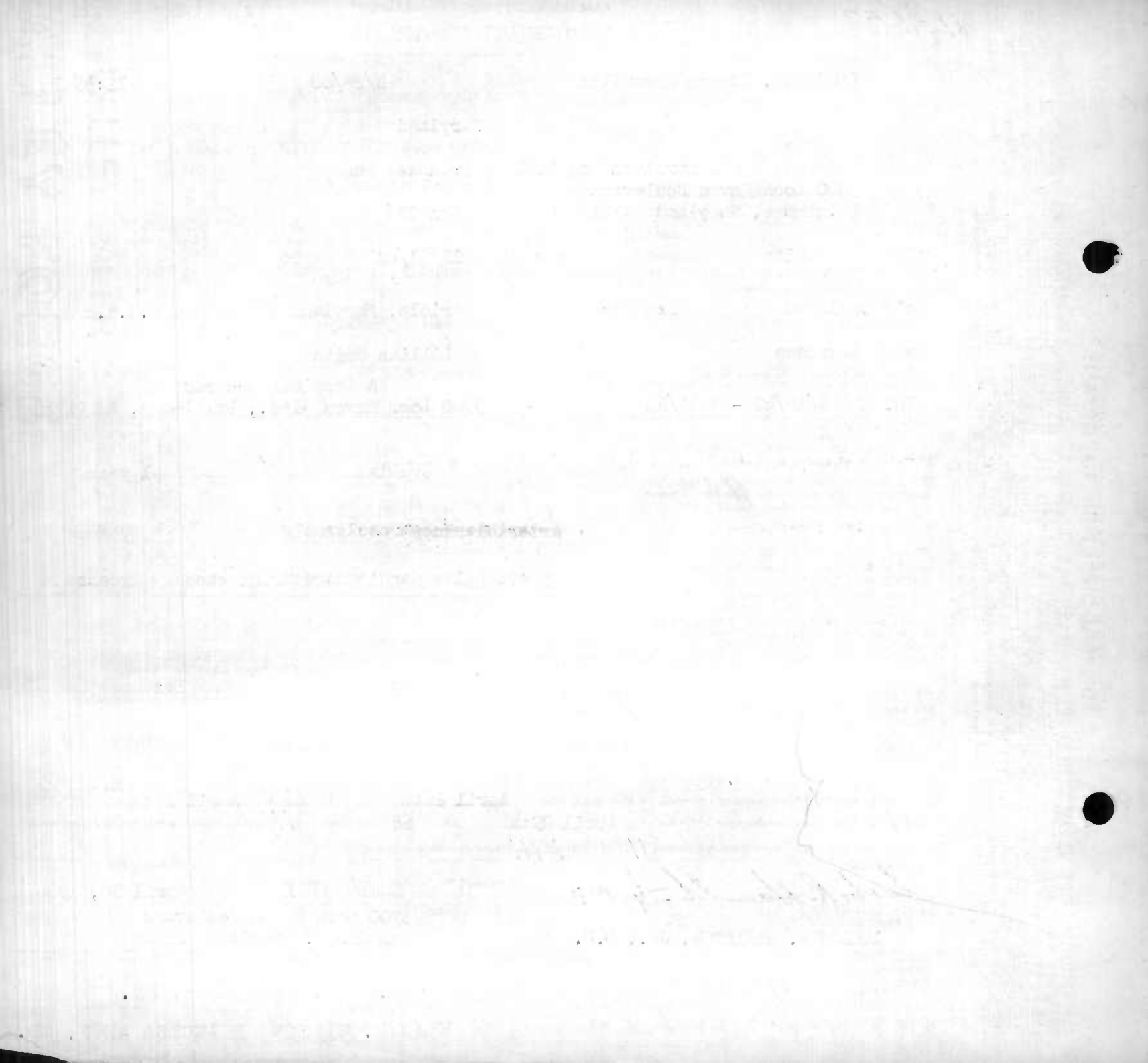
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-4671
<div style="display: flex; justify-content: space-between;"> <span><b>BIRTH NO.</b> 64-07163 68-4671</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="float: right;"><b>Grace A Dinsmore</b></span>			<b>2. DATE AND HOUR OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span><b>May 2, 1968.</b></span> <span>11:50 A. M.</span> </div>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>   <div style="border: 1px solid black; padding: 5px; width: 100px; margin-bottom: 5px;">00</div> </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b>   <b>1812 Wadsworth Way</b> </div> </div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <span><b>A. STATE</b> Md.</span> <span><b>B. COUNTY</b></span> </div>		
<b>C. CITY OR TOWN</b> <b>Baltimore</b>			<b>D. INSIDE CITY LIMITS?</b> <div style="display: flex; justify-content: space-between;"> <span>YES <input checked="" type="checkbox"/></span> <span>NO <input type="checkbox"/></span> </div>		
<b>E. STREET AND NUMBER</b> <b>1812 Wadsworth Way</b>					
<b>5. SEX</b> Female	<b>6. RACE</b> White	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 3/12/64	<b>9. AGE</b> (In years last birthday) 4	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) None
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) None			<b>11. BIRTHPLACE</b> (State or foreign country) Maryland		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.
<b>13. FATHER'S NAME</b> Lester S Dinsmore			<b>14. MOTHER'S MAIDEN NAME</b> Grace Kirk		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No			<b>16. SOCIAL SECURITY NO.</b> None		<b>17. INFORMANT</b> Lester S Dinsmore
			<b>ADDRESS</b> Same		
<b>18. CAUSE OF DEATH</b>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                   (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                   DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.             </div> <div style="width: 45%;"> <b>(A) IMMEDIATE CAUSE</b> <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF:   <b>(B) <i>Congenital Heart Disease</i></b> DUE TO, OR AS A CONSEQUENCE OF:   <b>(C)</b> </div> <div style="width: 10%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>   <i>1 min.</i> </div> </div>					
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b>  <i>Samuel L. O'Mansky</i>				<b>23B. DATE SIGNED</b>  <i>May 3/1968</i>	
<b>23C. PHYSICIAN'S NAME (Type)</b>  SAMUEL L. O'MANSKY				<b>23D. ADDRESS</b>  4523 Oak Lane Blvd. Balto. Md.	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> Burial		<b>24B. DATE</b> 5/6/68		<b>24C. NAME OF CEMETERY or CREMATORY</b> Meadowridge Memorial Pk	
				<b>24D. LOCATION</b> (City, town, or county) (State) Baltimore Maryland	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> MAY 3 1968		<b>25B. NAME OF REGISTRAR</b> Robert E. Taylor, M.D.		<b>25C. FUNERAL DIRECTOR</b> Leonard J. Ruck, Inc. Balto. Md. 21214	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-652 68-4672				BALTIMORE CITY HEALTH DEPARTMENT		68-4672	
CERTIFICATE OF DEATH				REG. NO. <span style="border: 1px solid black; padding: 2px;">X</span>			
1. NAME OF DECEASED (Type or Print) <b>LAWRENCE, Herman Granville</b>				2. DATE AND HOUR OF DEATH <b>4/29/68 12:45 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Somerset co 69-00</b>			
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>12/31/01</b>		9. AGE (In years last birthday) <b>66</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self employed</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Sea Food</b>		11. BIRTHPLACE (State or foreign country) <b>Oriole, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Harry Lawrence</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Smith</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 8/16/42 - 3/19/43</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>VA Hospital Records</b>	
				ADDRESS <b>3900 Loch Raven Blvd., Baltimore, Md 21218</b>			
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Arteriolar nephrosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>Hypertensive Cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>  <b>years</b>  <b>years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>442 X II</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>April 16th</b> 19 <b>68</b> to <b>April 29th</b> 19 <b>68</b> , that <b>(1)</b> (we) last saw the deceased alive on <b>April 29th</b> 19 <b>68</b> and that in <b>(1)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(1)</b> (We) (did) <b>(8/16/68)</b> view the body after death.							
23A. SIGNATURE <b>Carlos R. Hamilton, Jr. M.D.</b>				23B. DATE SIGNED <b>April 30, 1968</b>			
23C. PHYSICIAN'S NAME (Type) <b>CARLOS R. HAMILTON, JR., M.D.</b>				23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/2/1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>BEECHWOOD MEMORIAL CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>PRINCESS ANNE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>		25C. FUNERAL DIRECTOR <b>LEVIN R. WILSON</b>		ADDRESS <b>PRINCESS ANNE, MD.</b>	

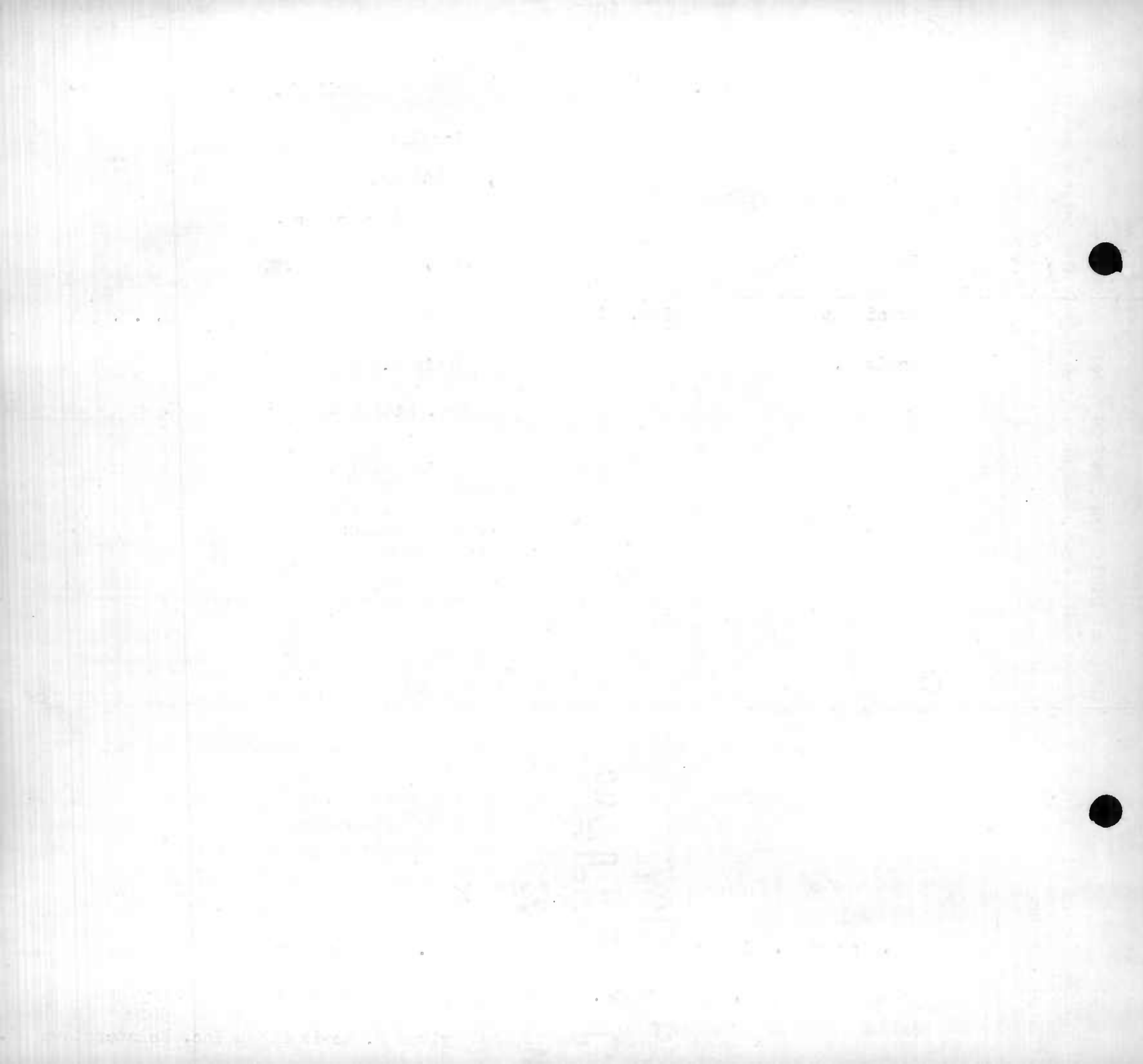


# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				REG. NO.	68-4673
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MANUEL L. KANN			April 30, 1968		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  42 SINAI HOSPITAL			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH Dec 7, 1900			9. AGE (In years lost birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Louis M.			14. MOTHER'S MAIDEN NAME Annie S.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Etta Kann
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C. V. A.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension		4 years
19A. DATE OF OPERATION 331X II			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 10/10 1934 to 4/30 1968, that (I) (we) last saw the deceased alive on 4/24 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Israel S. Zinberg			23B. DATE SIGNED 5/1/68		23C. PHYSICIAN'S NAME (Type)
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE May 2, 1968		24C. NAME OF CEMETERY or CREMATORY Balto. Hebrew
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1968			25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son Inc. Reisterstown Rd.
24D. LOCATION (City, town, or county)			24E. LOCATION (State)		
Baltimore			Maryland		





**FUNERAL DIRECTOR: IMPORTANT**

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C-500		68-4674		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4674	
1. NAME OF DECEASED (Type or Print) <b>Jacob Cohen</b>				2. DATE AND HOUR OF DEATH <b>5-1-68</b> <b>7:40 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 Church Home + Hosp</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto</b>			
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN <b>Balto</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>				8. DATE OF BIRTH <b>5-12-92</b>		9. AGE (In years last birthday) <b>76</b>	
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>No formal name</b>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-32-2191</b>		17. INFORMANT <b>MR. IRVING COHEN</b>	
18. <b>3300 XI</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary embolus 12hrs</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>PHLEBOSCLEROSIS + Phlebotrombosis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(?) AGE, DIABETES MELLITUS +</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>5-60.0 II</b>				(C) <b>CONGESTIVE HEART FAILURE</b>			
19A. DATE OF OPERATION <b>4-24-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Inguinal hernia, bilateral</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-18-68</b> to <b>5-1-68</b> , that (I) (we) lost the deceased alive on <b>5-1-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Ricardo M. Tuason M.D.</b>				23B. DATE SIGNED <b>5-1-68</b>		23C. PHYSICIAN'S NAME (Type) <b>Ricardo M. Tuason M.D.</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>5/2/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Morgan Abraham</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>				25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>				25C. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son, INC</b>			
25D. ADDRESS <b>Garrison</b>							

Church House + Chapel

no before Jan  
Plumber  
M W

1800 E. Lombard St  
2-12-28  
Lithuania

Polymers and resins

PH LEAD CO (CROSSLAND) + PHLEAD CO  
(?) REC'D DIRECT MAILING  
CONTACTING RECENT FAILURE

4-24-28 Industrial Bureau, District No

Ricardo H. Turner H.D.  
Ricardo H. Turner H.D.  
CO

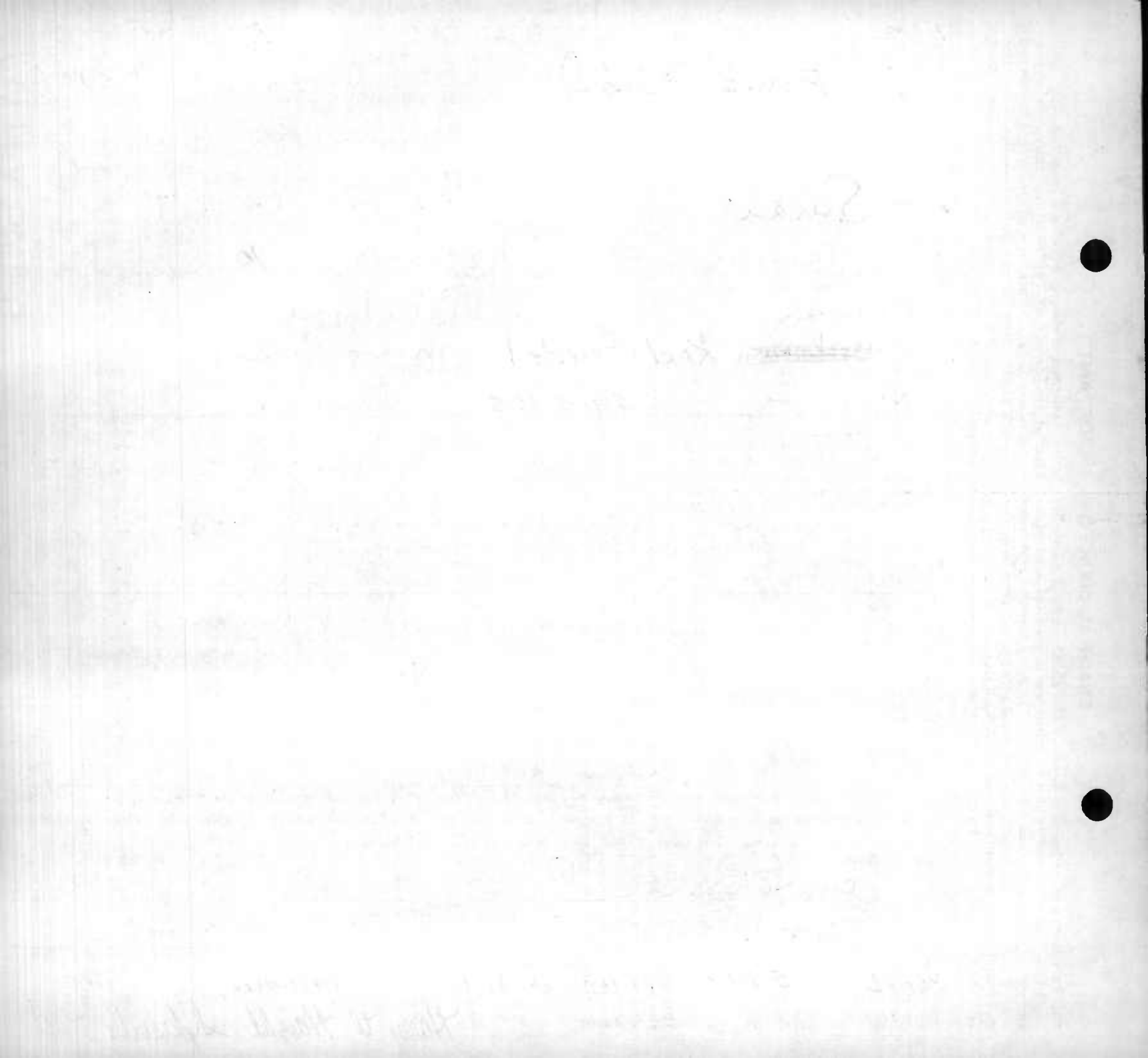
2-1-28  
2-1-28

Clear on stone + the ground

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 4675
F-634		68- 4675		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Frank Friedel		4-29-68 9:37 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE		
			B. COUNTY		
42 Sinai			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			Box - 249 Rt # 1		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M	Caucasian	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1-15-78	90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Former		former		Palestine	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unknown Karl Friedel			Marie Paulus		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		219-12-2205		daughter	
18. 531.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Peritonitis -		
			(B) Refracted gastric ulcer		
			(C)		
19. 540.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Gastrointestinal hemorrhage		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4-22-68 to 4-29-68, that (I) (we) last saw the deceased alive on 4-29-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Sam LeBaron M.D.				4-29-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Sam LeBaron M.D.				Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5-1-68		Gardens of Faith	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR			
Baltimore, Md.		Harry W. Haight			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS	
MAY 3 1968		Robert E. Taylor, M.D.		Lynchville, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. EXAMINER'S OFFICE

H-163		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4676	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		NATHAN HENRY HUBBARD		4-30-68 3:20PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
THE JOHNS HOPKINS HOSPITAL				MARYLAND TALBOT	
33				C. CITY OR TOWN	
				EASTON 20-27	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				112 TRED AVON AVENUE	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8-6-11	56	11. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Auditor		Income Tax Div.		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
MELVIN HUGHLETT HUBBARD		EMILY JANE DILLON		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
yes WW 11		01-6058		Mrs. Nathan Hubbard, Easton, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3 hours	
ANTECEDENT CAUSES		(B) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) myocardial ischemia	
420.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		rheumatic valvular disease 32 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
4/30/68		rheumatic aortic + mitral disease		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
no					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 23 1968 to April 30 1968, that (I) (we) last saw the deceased alive on April 30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Thomas A. Broadie, M.D.		April 30, 1968			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
THOMAS A. BROADIE, M.D.		JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/3/1968		Spring Hill	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 3 1968		Robert E. Farber		MURDOCK E. NEWMAN & SON, Easton, Md.	
				ADDRESS	

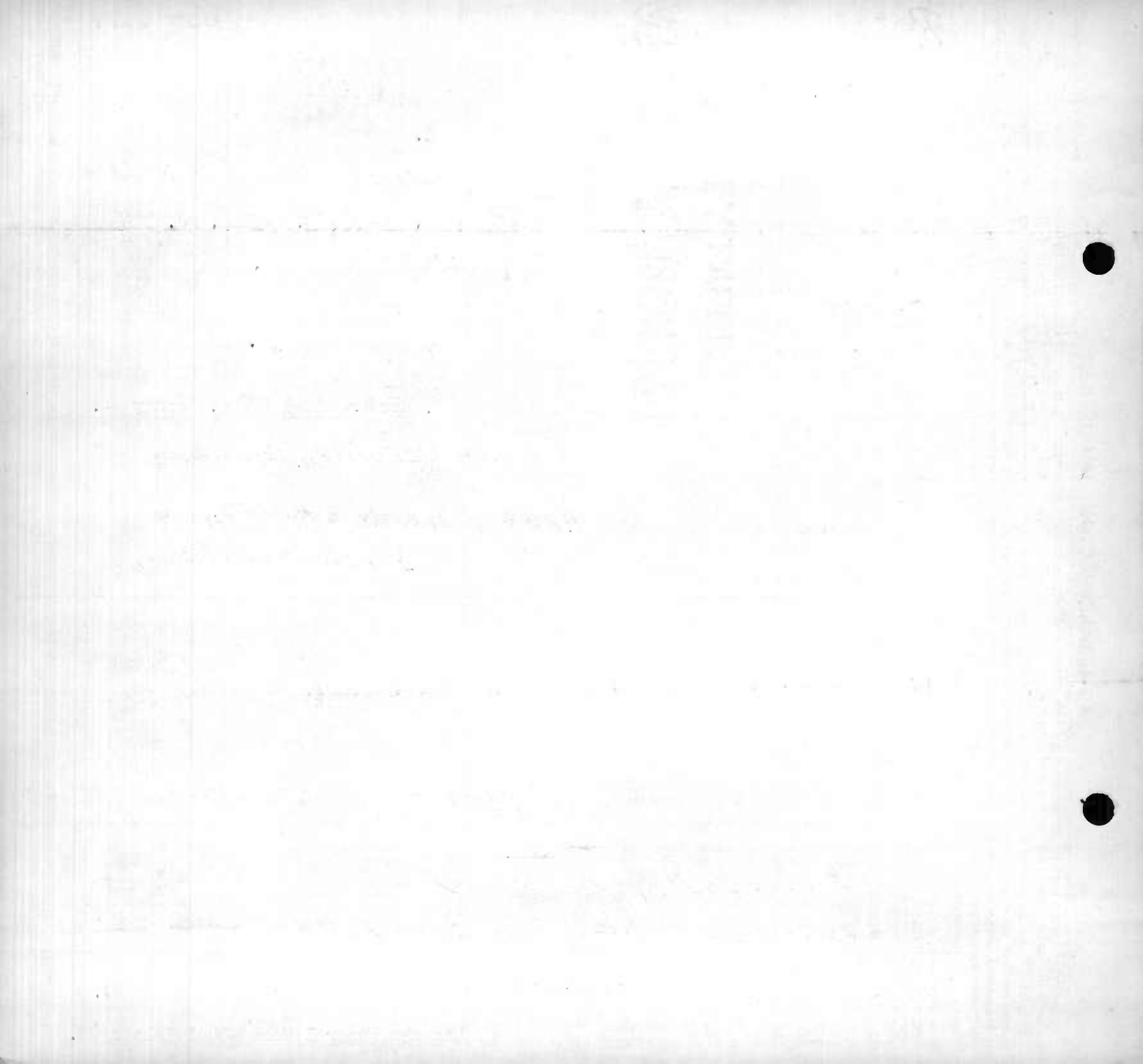
A. H. [unclear] [unclear]



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

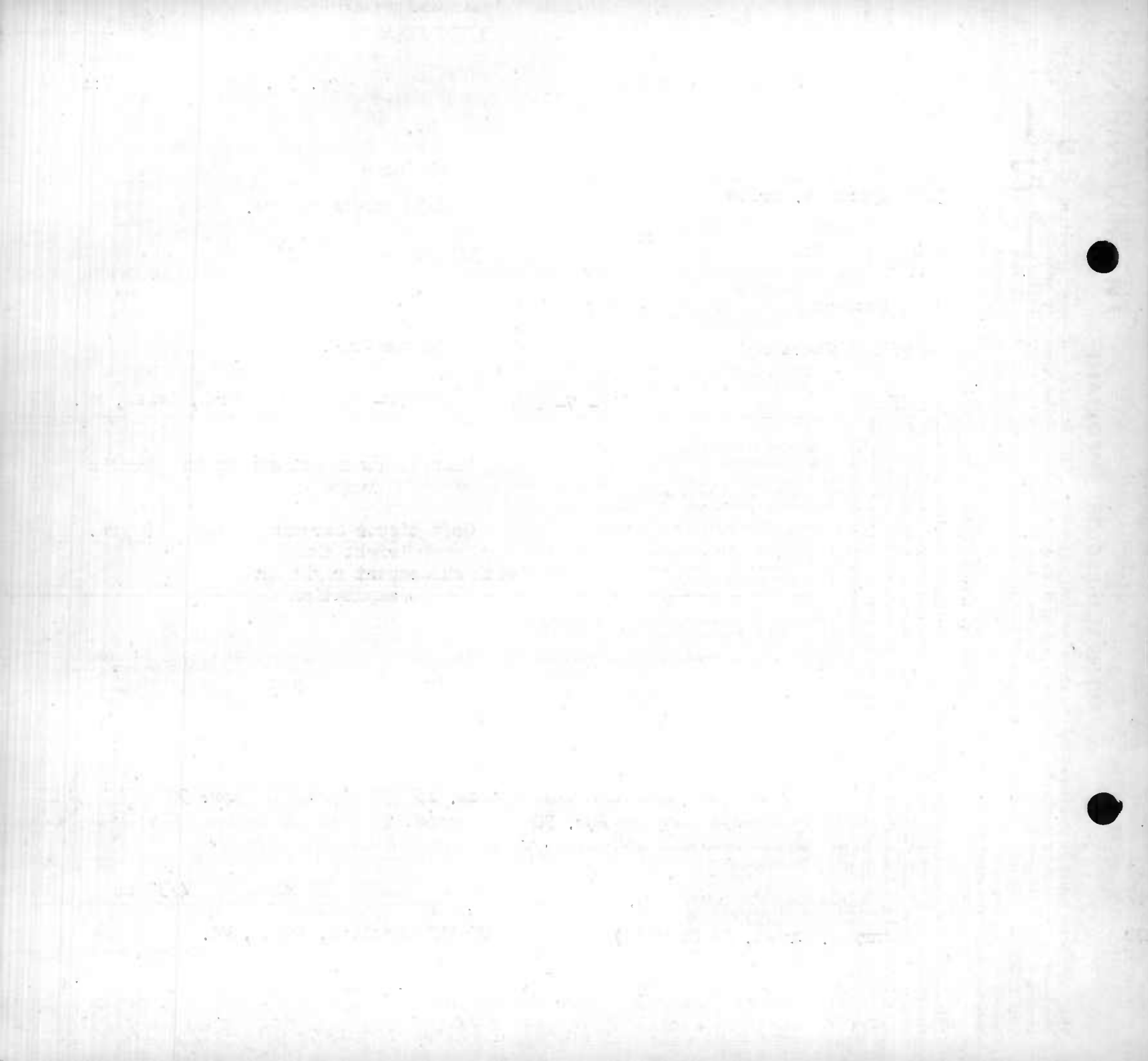
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4677</b>	
R-360		68-4677 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ALBERT A. REEDER</b>		2. DATE AND HOUR OF DEATH <b>1/30/68</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1302 Morling Avenue</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>127 N. Janney St. Balto. Md. 21224</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/12</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>silversmith</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Stieff Silver</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore /City</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles Reeder</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Gerkey</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>215-01-3959</b>		17. INFORMANT <b>Eva B. Reeder (wife)</b>	
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE CORONARY THROMBOSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC &amp; HYPERTENSIVE CARDIO-VASC. DISEASE</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROTIC &amp; HYPERTENSIVE CARDIO-VASC. DISEASE</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.11 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 8 19 67</b> to <b>Apr 30 19 68</b> , that (I) (we) last saw the deceased alive on <b>Apr. 23 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. Lemiscan</b>		23B. DATE SIGNED <b>5/1/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>A. Lemiscan M.D.</b>		23D. ADDRESS <b>2608 E. BALTIMORE ST</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>5/4/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Belair Memorial Garden</b>	
24D. LOCATION <b>Bel Air Md.</b>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>	
25D. ADDRESS <b>7401 Belair Rd.</b>					



**FUNERAL DIRECTOR: IMPORTANT**

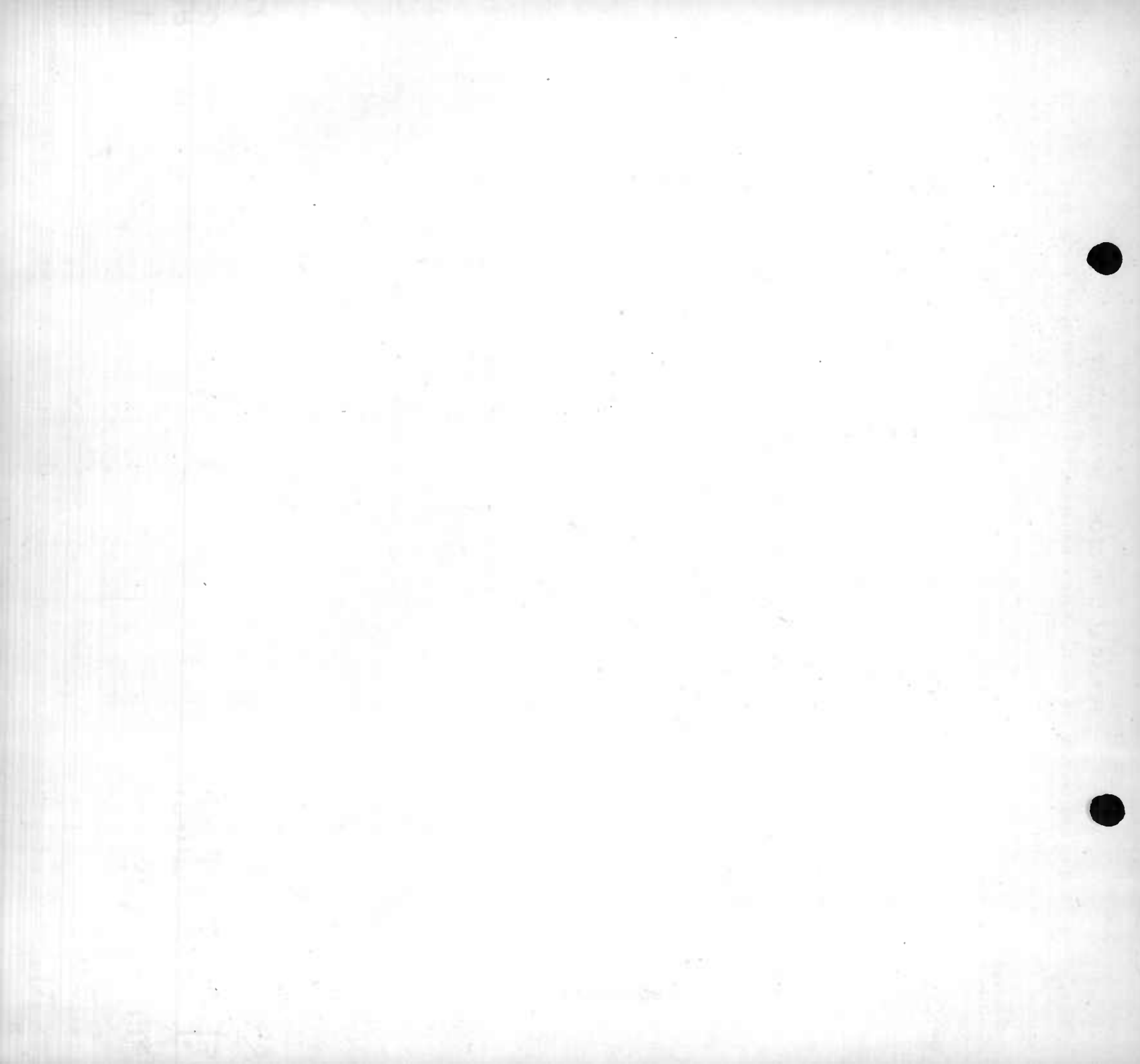
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.				68- 4678			
1. NAME OF DECEASED (Type or Print) <b>James Lee Jackson</b>								2. DATE AND HOUR OF DEATH <b>Apr. 30, 1968</b> <b>7:17 A.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Pk. Drive</b>								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>15-09</b>							
5. SEX <b>M</b>				6. RACE <b>Col</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/27/20</b>		9. AGE (In years last birthday) <b>48</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Messman</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Seafarer</b>				11. BIRTHPLACE (State or foreign country) <b>Ga.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Willie Jackson</b>								14. MOTHER'S MAIDEN NAME <b>Geneva Wright</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-07-0056</b>				17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>							
18. <b>172.7 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive tumor metastases to lungs</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Soft tissue sarcoma of the right thumb with subsequent right arm amputation</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>3 yrs.</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>191.6 II</b>															
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that <b>(A)</b> (this hospital) attended the deceased from <b>Feb. 15</b> 19 <b>68</b> to <b>Apr. 30</b> 19 <b>68</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>Apr. 30</b> 19 <b>68</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (We) (did) <b>(did not)</b> view the body after death.															
23A. SIGNATURE <b>Henry S. Crist, M.D.</b>								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/30/68</b>					
23C. PHYSICIAN'S NAME (Type) <b>Henry S. Crist, SA Surg (R)</b>								23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>5-4-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Ashtutur Mem. Ph. Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>				25C. FUNERAL DIRECTOR <b>Urlington S. Phillips</b>				ADDRESS <b>1727 N. Mount</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>RICHARD FRANKLIN</b>		2. DATE AND HOUR OF DEATH <b>4-27-68</b> <b>2-45 P.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. IN <del>100</del> CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3604 W. LEXINGTON ST.</b>	
5. SEX <b>M.</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-10-1908</b>	9. AGE (In years lost birthday) <b>60</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINISTER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>John Franklin</b>		14. MOTHER'S MAIDEN NAME <b>Mary Campbell</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown. If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>280-10-0455</b>		17. INFORMANT <b>Evelyn Franklin</b> Same	
18. <b>185 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CANCER PROSTATE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>with METASTASIS.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 Months</b>	
MEDICAL CERTIFICATION					
177X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0 Oct. 1967</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTESTINAL OBSTRUCTION</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-29-1968</b> to <b>4-27-1968</b> , that (I) (we) last saw the deceased alive on <b>4-27-1968</b> and that in (my) <b>(aur)</b> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Zakaud Din Vera</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>ZAKAUDDIN VERA</b>				23D. ADDRESS <b>LUTHERAN HOSPITAL.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-2-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cornier Mem. Park</b>	
24D. LOCATION <b>MD.</b>		24E. CITY, TOWN, or county (State)			
25A. DATE RECD BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>William J. Shelly</b>	
				ADDRESS <b>1727 M. Mount</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 4680
V-563		68- 4680		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>MARK VONHARTZ</b>			2. DATE AND HOUR OF DEATH <b>MAY 1, 1968</b>   <b>8:55 P</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b> <b>33rd AND CALVERT STS</b> <b>BALTIMORE, MARYLAND 21218</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4 PALMER GREEN CROSSKEYS</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-25-88</b>	9. AGE (In years lost birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>CARL VONHARTZ</b>		
14. MOTHER'S MAIDEN NAME <b>ERENSTINE SCHMIDT</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>145-05-4336</b>			17. INFORMANT <b>Mrs HAMILTON OWEN (Sister)</b> Address: <b>4 Palmer Green Crosskeys Baltimore Md</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute peritonitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>Carcinoma of rectum</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of rectum</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>C. K. W.</b> (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>154X II</b>					
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>MAY 1, 1968</b> to <b>MAY 1, 1968</b> , that (we) last saw the deceased alive on <b>MAY 1, 1968</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.					
23A. SIGNATURE <b>William H. Spencer - Strong</b>				23B. DATE SIGNED <b>May 1, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM H. SPENCER STRONG</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		24B. DATE <b>5/4/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hillside</b>	
24D. LOCATION <b>Rutherford,</b>		24E. (City, town, or county) (State) <b>N. J.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>	



922

MAY 19

MAY 19

WATKINS

YALINER CROWN CO.

X 3-22-88 30

NEW YORK

BREWSTER SCHMIDT

WASHINGTON CROWN CO.

Acute Prostate

Consensus of opinion

W. K. Miller

YES

YES

NO

MAY 11

82

MAY 13

MAY 1

William H. Jones - Stanger

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-261 68-4681				BALTIMORE CITY HEALTH DEPARTMENT		REG NO. 68-4681	
1. NAME OF DECEASED (Type or Print) <b>(PHILLIP) P. CARL MUSGROVE</b>				2. DATE AND HOUR OF DEATH <b>4/30/68 9<sup>40</sup> P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>9-03</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>YOLANDA ROAD 3604</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/11/11</b>	9. AGE (In years lost birthday) <b>56</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PARK CIRCLE MOTOR CO.</b>		11. BIRTH PLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALBERT M. MUSGROVE</b>				14. MOTHER'S MAIDEN NAME <b>EMILY M. CHANEY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-3904</b>		17. INFORMANT <b>MR ALBERT MUSGROVE</b>		ADDRESS <b>3 SADDLE CIRCLE NEWARK DEL.</b>	
18. <b>431.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral hemorrhage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>331X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>W. K. W.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <b>April 26 1968</b> to <b>April 30 1968</b> , that (I) <u>(we)</u> lost saw the deceased alive on <b>April 30 1968</b> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <b>Enrique Cipriani M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/30/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>ENRIQUE CIPRIANI M.D.</b>				23D. ADDRESS <b>33<sup>rd</sup> and Calvert Sts.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/3/68</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>			

MEMORIAL HOSPITAL  
 10/11/11  
 W M

MARYLAND  
 ALBERT M. MORGAN  
 EMILY M. CHASE  
 MY GREAT MOTHER

(U.K.W.)

Yes

April 10 1912

30/3/12  
 M.O. and Cabot 20

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-000		68-4682		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-4682	
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <i>Thomas Lowe</i>				
2. DATE AND HOUR OF DEATH <i>5/2/68</i>					2. DATE AND HOUR OF DEATH <i>2:00 AM</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore City</i>				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>					C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER <i>2129 N. Calvert Street</i>				
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov 17th 1911</i>		9. AGE (In years lost birthday) <i>56 yrs</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>WELDING</i>		11. BIRTHPLACE (State or foreign country) <i>Tenn</i>		12. CITIZEN OF WHAT COUNTRY? <i>(America) USA</i>			
13. FATHER'S NAME <i>Jacob (Long) LOWE</i>					14. MOTHER'S MAIDEN NAME <i>Nancy Bueckes</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i>					16. SOCIAL SECURITY NO.		17. INFORMANT <i>Sister Mrs. Charles Johnson</i>		
18. <i>4915X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Cerebral abscess</i> <i>Cerebral Tumor</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Brain metastasis also. Asphyxiated during Body.</i> <i>Perianal duct carcinoma</i> <i>W.K.W.</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <i>the</i> (this hospital) attended the deceased from <i>4/28/68</i> to <i>5/2/68</i> , that (I) <i>we</i> last saw the deceased alive on <i>5/1/68</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>we</i> (did) <i>did not</i> view the body after death.									
23A. SIGNATURE <i>Dermot Campbell M.B.</i>					23B. DATE SIGNED <i>5/2/68</i>				
23C. PHYSICIAN'S NAME (Type) <i>DERMOT CAMPBELL MD.</i>					23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i> <i>Union Memorial Hospital</i>				
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>5/7/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Sharp</i>		24D. LOCATION (City, town, or county) (State) <i>Caryville, Tenn.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>H.W. Jenkins &amp; Sons Co.</i>		ADDRESS <i>4905 York Rd. Balto. 12, Md.</i>			

2/11/11  
Housing Mill 20742  
5221 N. 2nd Street  
Tomball, Texas  
Houston, Texas

Robert Jones  
2121 N. 2nd Street  
Tomball, Texas

Robert Jones  
2121 N. 2nd Street  
Tomball, Texas

YES

2/11/11

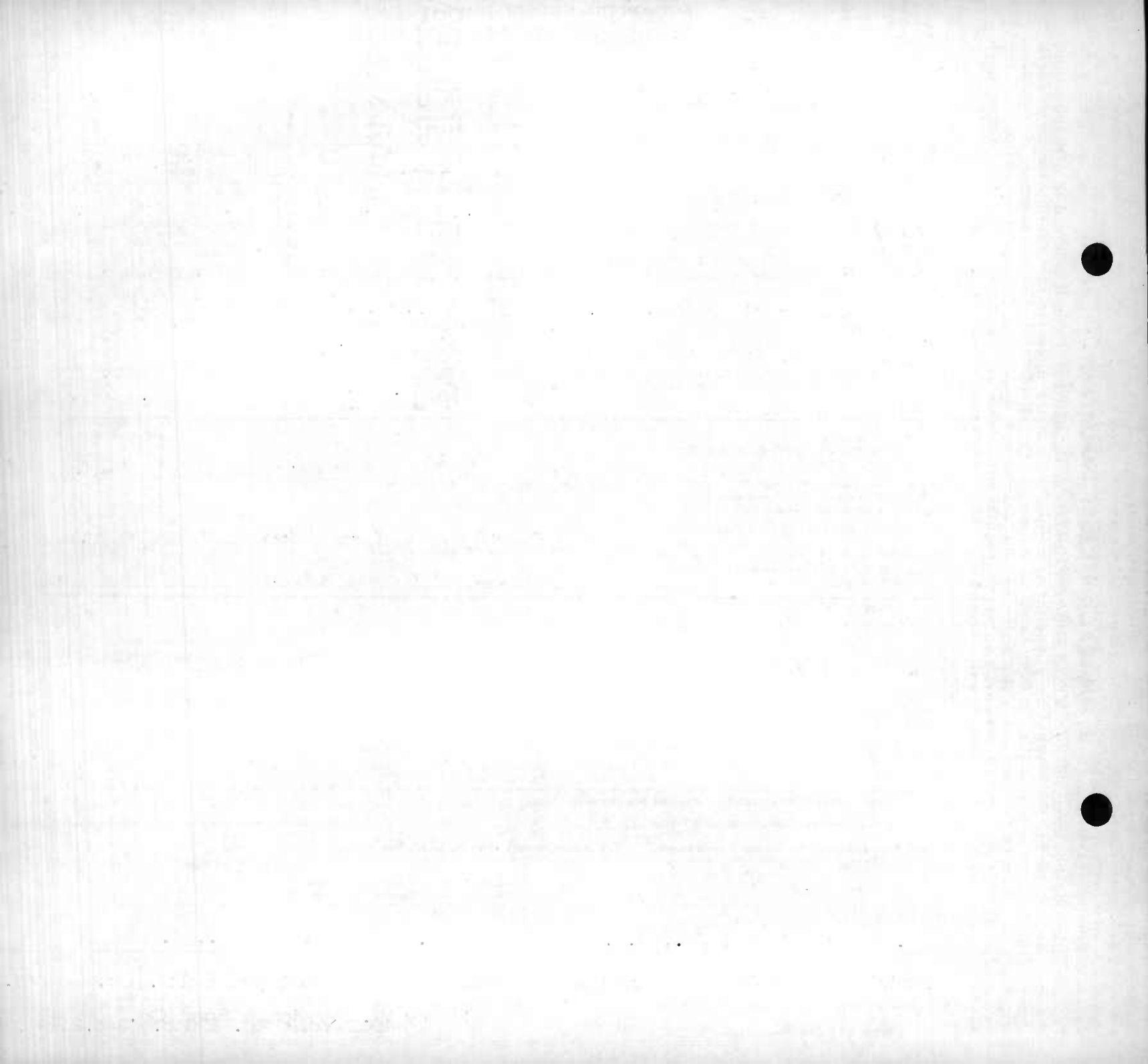
2/11/11

Robert Jones  
2121 N. 2nd Street  
Tomball, Texas

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 4683
H-536 68- 4683		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>Henderson, Mr. George Howard</b>		2. DATE AND HOUR OF DEATH <b>May 3, 1968 1:41 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>91 Keswick</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>700 W. 40th Street</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1884</b>	9. AGE (In years lost birthday) <b>83</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>George Washington Henderson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Arthur</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-03-1274</b>		17. INFORMANT <b>Heleen E. Leach, P.N. - Keswick records</b>	
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Diffuse bronchopneumonia</b> (B) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Generalized atherosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>3 yrs.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.0 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jul 16 1962</b> to <b>May 3 1968</b> , that (I) (we) last saw the deceased alive on <b>May 3 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Hunter Wilson, Jr., M.D.</b>		23B. DATE SIGNED <b>5-3-68</b>		23C. PHYSICIAN'S NAME (Type) <b>E. Hunter Wilson, Jr., M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-6-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Balto., Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Henry W. Jenkins &amp; Sons Co.</b>		25D. ADDRESS <b>4905 York Rd. Balto., Md. 21212</b>			





**FUNERAL DIRECTOR: IMPORTANT**

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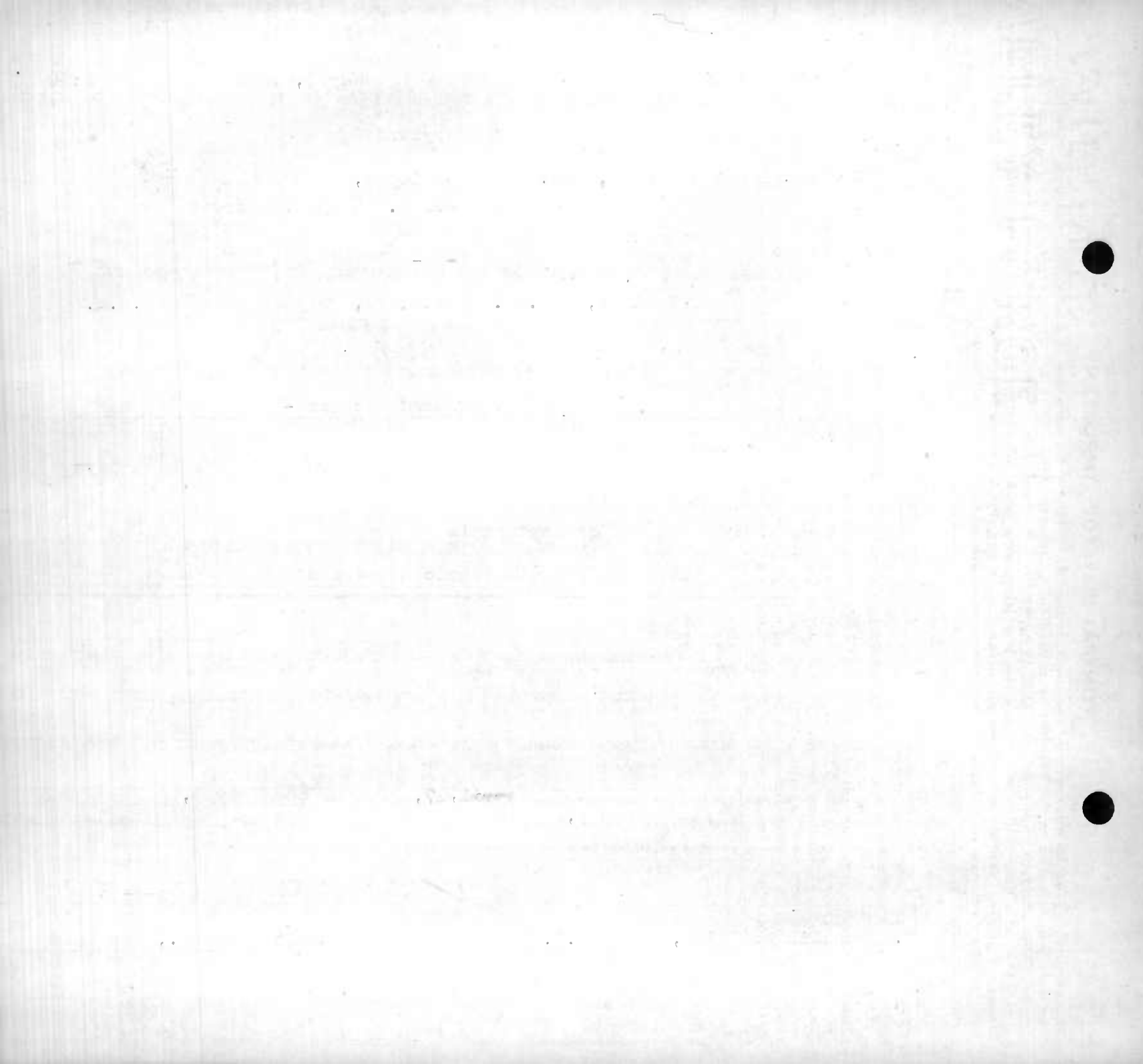
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 4684</b>	
J-520		68- 4684 <b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>MAGGIE JONES</b>		2. DATE AND HOUR OF DEATH <b>5-2-68 6 15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MONTEBELLO STATE HOSPITAL BALTIMORE 21218</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1715N. Smallwood St</b>			
5. SEX <b>Female</b>	6. RACE <b>N Col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/11/1914</b>	9. AGE (In years lost birthday) <b>54</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>	
13. FATHER'S NAME <b>John Clark</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Jessie Jones</b> ADDRESS	
18. <b>433.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRAL THROMBOSES</b> (B) <b>ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>	
MEDICAL CERTIFICATION					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>332X II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>9-19 1967</b> to <b>5-2 1968</b> , that (1) (we) last saw the deceased alive on <b>5-2 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Irving L. Cooperstein</b> DEGREE				23B. DATE SIGNED <b>5-2-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>IRVING L. COOPERSTEIN</b> DEGREE				23D. ADDRESS <b>MONTEBELLO HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-6-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cmt</b>	
24D. LOCATION (City, town, or county) <b>Balto Md</b>		24E. (State) <b>Md</b>		24F. (Country) <b>USA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Elmer Wilson</b> ADDRESS <b>1000 Broadway</b>	

Information by phone from Montebello State Hospital  
Medical Records office - Race & age - 5/7/68  
8013

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">68-4685</span>	
68-4685		CERTIFICATE OF DEATH	
BIRTH NO. <span style="float: right;">G-420</span>			
1. NAME OF DECEASED (Type or Print) <span style="float: right;">Mildred Giles</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">May 3, 1968 6:00 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">39 Provident Hospital, Inc.</span>		A. STATE <span style="float: right;">Maryland</span> B. COUNTY	
		C. CITY OR TOWN <span style="float: right;">Baltimore</span> D. INSIDE CITY LIMITS <span style="float: right;">YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></span>	
		E. STREET AND NUMBER <span style="float: right;">2408 W. Baltimore Street</span>	
5. SEX <span style="float: right;">Female</span>	6. RACE <span style="float: right;">Negro</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">7-28-33</span>
		9. AGE (In years last birthday) <span style="float: right;">34</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">Londontown, Mfg.Co.</span>	11. BIRTHPLACE (State or foreign country) <span style="float: right;">Baltimore, Maryland</span>
12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A.</span>			
13. FATHER'S NAME <span style="float: right;">William Bolden</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">Mildred Sanders</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">No</span>		16. SOCIAL SECURITY NO. <span style="float: right;">220-30-1287</span>	17. INFORMANT <span style="float: right;">Mildred Jackson - Mother</span>
		ADDRESS <span style="float: right;">SAME</span>	
18. <span style="float: right;">629.41</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">Uremia</span> (B) <span style="float: right;">Septicemia</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="float: right;">Acute Pelvic Infection</span>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">5 days</span>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="float: right;">626X II</span>			
19A. DATE OF OPERATION <span style="float: right;">0</span>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <span style="float: right;">No</span>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">April 27, 1968</span> to <span style="float: right;">May 3, 1968</span> that (I) (we) last saw the deceased alive on <span style="float: right;">May 3, 1968</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="float: right;">G. Franklin Phillips, M.D.</span>		23B. DATE SIGNED <span style="float: right;">5-3-68</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">G. Franklin Phillips, M.D.</span>		23D. ADDRESS <span style="float: right;">558 McMechen Street Balto., Maryland</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>	24B. DATE <span style="float: right;">4-7-68</span>	24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Arbutus Man. Park</span>	24D. LOCATION (City, town, or county) (State) <span style="float: right;">Arbutus Md.</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">MAY 3 1968</span>	25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Taylor</span>	25C. FUNERAL DIRECTOR <span style="float: right;">Chas. O. Wilson 1000 Brantly Dr.</span>	



R-3001

68-4686

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-4686

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

NORAC. ROTH

2. DATE AND HOUR OF DEATH

5-1-68

5:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)90 LITTLE SISTERS OF THE POOR  
1200 VALLEY STREET  
BALTIMORE, MARYLAND 212024. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS

YES ☒ NO ☐

E. STREET AND NUMBER

1200 VALLEY STREET

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Feb 15/1883 83

9. AGE (In years  
last birthday)

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CHARWOMAN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

IRELAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

JOHN MORAN

14. MOTHER'S MAIDEN NAME

CATHERINE WARD

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

212-24-8788

17. INFORMANT

1200 VALLEY ST.  
LITTLE SISTERS OF THE POOR BALT., MD. 21202

18.

410.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Massive Myocardial infarction

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Q. S. C. V. I. D

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

420.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

O

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1966 to May 1 1968,  
that (I) (we) last saw the deceased alive on May 1 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stanley Ankudas

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

5.3.68

23C. PHYSICIAN'S  
NAME (Type)

STANLEY ANKUDAS, M.D.

23D. ADDRESS

1101 MAIDEN CHOICE LANE BALT., MARYLAND

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5/4/68

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Hill

24D. LOCATION

Baltimore

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 6 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

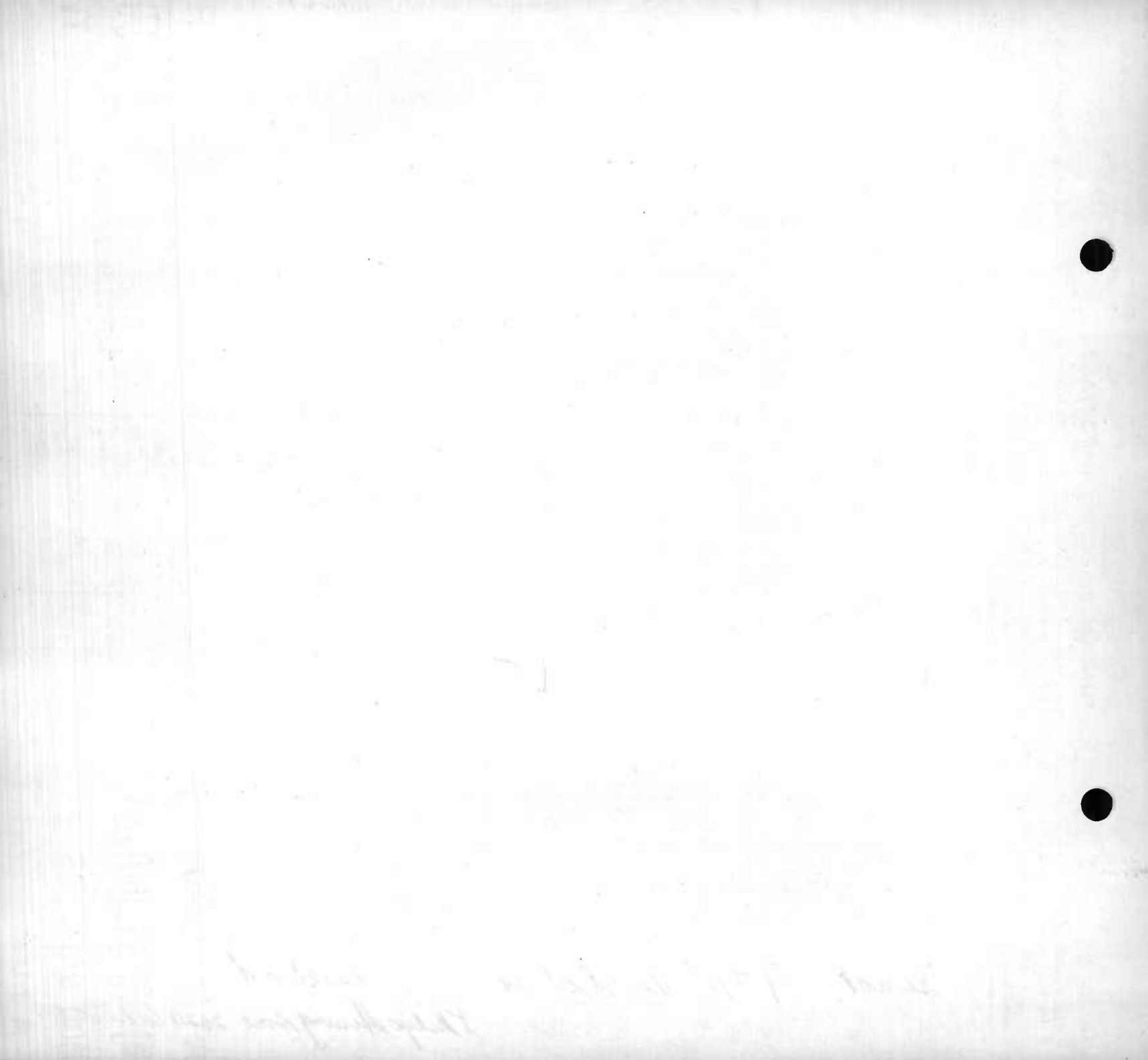
25C. FUNERAL DIRECTOR

Philip Hewing Sons 2024 Calhoun St

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4687	
Z-260 68-4687		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MR. GUSTAV ZUCKER</b>		2. DATE AND HOUR OF DEATH <b>MAY 1, 1968 1:45 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME AND HOSP.</b>		A. STATE <b>Maryland</b> 8. COUNTY <b>Baltimore Co</b>			
C. CITY OR TOWN <b>Dundalk</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <b>1909 SNYDER AVE</b>					
5. SEX <b>Male</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-6-05</b>	9. AGE (In years last birthday) <b>61-2</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sgt. Baltimore County Police Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM ZUCKER</b>		14. MOTHER'S MAIDEN NAME <b>MARY Magersupp</b>		ADDRESS <b>Md. 21222</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-07-4622</b>		17. INFORMANT (Wife) <b>Mrs. Ruth Zucker, 1909 Snyder Ave. Dundalk,</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Carcinoma of the Pancreas - Distant Metastases</b>			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
157X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 27 1968</b> to <b>May 1 1968</b> , that (I) (we) lost sight of the deceased alive on <b>May 1 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Veneracion</b>		23B. DATE SIGNED <b>May 1, 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>VENERACION</b>	
23D. ADDRESS <b>Church Home &amp; Hospital</b>		23E. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/4/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Faldut</b>	



MAY 1 1955

MAY 1 1955

CHURCH MEMBERS AND

MEMBERS ARE

7-6-55

WHITE

MARRIAGE

WILLIAM ZUCKER

MARY

CONGREGATION OF THE

PASTOR & BOARD

APR 1 1955

MAY 1

OFFICERS

CHURCH

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-515		68-4688		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4688	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Mrs. Clara Champness			
2. DATE AND HOUR OF DEATH 4/29/68 at 9:10 P. M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 48th Gen. Hospital				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Md. Balt. Co. 53-09				5. CITY OR TOWN TIMONIUM.			
6. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				E. STREET AND NUMBER 106 Longdale Rd			
5. SEX D F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/28/10	
9. AGE (In years last birthday) 58		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		11. BIRTHPLACE (State or foreign country) Md.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Ramsey-Scarlett Co.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Wm. Roberts	
14. MOTHER'S MAIDEN NAME Delma Middleton		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 212-28-3940		16. SOCIAL SECURITY NO. 214-034816		17. INFORMANT Edward J. Champness - Same	
18. 436.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Encephalopathy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19. 334 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/27/1968 to 4/29/1968, that (I) (we) last saw the deceased alive on 4/27/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. Swaroop MD				23B. DATE SIGNED 4/29		23C. PHYSICIAN'S NAME (Type) S. Swaroop MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/3/68		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial		24D. LOCATION (City, town, or county) (State) Timonium, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1968		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR John C. Miller Inc. - 6415 Belair Rd.		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 4689</b>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SHEILA DIANE McFADDEN</b>		2. DATE AND HOUR OF DEATH <b>5/2/68 5:15 PM.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY OF MARYLAND HOSPITAL</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>712 BRUNE STREET 17-03</b>		
5. SEX <b>F</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/12/48</b>	9. AGE (In years last birthday) <b>20</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>GUST McFADDEN</b>		
14. MOTHER'S MAIDEN NAME <b>EARTHA</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Chart,</b>		
18. <b>292.5 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>SICKLE CELL(ES) DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION <b>292.6 II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>RHEUMATIC HEART DISEASE</b>		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 11 1968</b> to <b>MAY 2 1968</b> , that (I) (we) last saw the deceased alive on <b>MAY 2 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <b>L. L. Williams, M.D.</b>		23B. DATE SIGNED <b>5/2/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>MARIE W. Williams, M.D.</b>		23D. ADDRESS <b>UNIVERSITY OF MARYLAND HOSP</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		
25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>		25C. FUNERAL DIRECTOR <b>1206 W North Ave</b>		

Handwritten text at the top of the page, possibly a header or title, including the word "REPORT" and some illegible numbers and dates.

Handwritten text in the middle section, appearing to be a list or series of notes, with some words like "REPORT" and "RESULTS" visible.

Handwritten text in the lower middle section, possibly a conclusion or summary, with some words like "REPORT" and "RESULTS" visible.

Handwritten text at the bottom of the page, including a large circle and some illegible text, possibly a signature or date.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4680

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68-4680

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CALEB WEEKS (CLABE)</b>		2. DATE AND HOUR OF DEATH <b>MAY 4, 1968 10:20 p. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>16-01</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>N.M. CARROL HOME FOR THE AGED</b> <b>822 N. CARROLTON AVE</b> <b>BALTIMORE, MD 21217</b>				C. CITY OR TOWN <b>Balto</b>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>822 N CARROLTON AVE</b>	
5. SEX <b>MALE</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1881</b>	9. AGE (In years last birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-14-1088 A</b>		17. INFORMANT ADDRESS	
18. <b>4/12.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>D ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>GENERALIZED ARTERIOSCLEROSIS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. <b>4/20.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>NONE</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>10th January 1968</b> to <b>28th April 1968</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>April 28th 1968</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <b>Ahmed Kutty md</b>				23B. DATE SIGNED <b>5-5-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>AHMED KUTTY MD</b>				23D. ADDRESS <b>V. A. Hospital, Fort Howard, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Ave</b>			

M.M. Carter, Jr. 1881  
622 N. Carroll St.  
Baltimore, Md. 21201  
M.M. N

ARTERIO-SCLEROTIC HEART  
DISEASE WITH CORONARY  
FIBROSIS  
CONGESTED HEART

NO  
NO  
NO

THOMAS KUTTY MD  
KUTTY MD

V.A. Hospital, Fort Howard, Md.  
2-2-18

April 25th 1881  
2-2-18



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 4691 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 4691

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MAXWELL, NIOLET</b>		2. DATE AND HOUR OF DEATH <b>5-2-68 4<sup>30</sup></b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>1212 E. OLIVER ST</b>		
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/22/06</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodial</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CITY BALTO</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
13. FATHER'S NAME <b>WILLIAM ASKINS</b>			14. MOTHER'S MAIDEN NAME <b>SARAH CAREY</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-26-2123</b>		17. INFORMANT <b>Sarah Blanco 1212 E. Oliver St</b>	
18. <b>573.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>HEPATIC COMA</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CHRONIC LIVER DISEASE</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>583X II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NO</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/23/1968</b> to <b>5/2/1968</b> , that (I) (we) lost saw the deceased alive on <b>5/2/1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John R Stone, MD</b>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <b>JOHN R. STONE, MD</b>			23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Men PK</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Joseph L. Locks</b>	
ADDRESS <b>1304 N. Central Ave</b>					

1912-13  
1913-14  
1914-15

Johns Hopkins

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4692

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN A. SCOTT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> MAY 2, 1968 Hour 7:00 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year May 2, 1968 Hour 7:00 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 5-26-31		10. AGE (In years lost birthday) 36 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Ophelia Butler	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11-5-52 to 6-25-54		17. SOCIAL SECURITY NO.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E880X Graniocerebral Injury		21. AUTOPSY? (Yes or No) Yes	
14B. KIND OF BUSINESS OR INDUSTRY		18. INFORMANT Thelma Scott	
13. FATHER'S NAME John A. Scott, Sr.		ADDRESS 221 N. Fremont Ave	
14C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E900.0 II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) unk.	
22D. TIME OF INJURY (APPROX.) May 1, 68 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) unk.		22F. HOW DID INJURY OCCUR? Subj. apparently fell down steps.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-6-68	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. PK.		24D. LOCATION (City, town, or county) (State) Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1968		25B. NAME OF REGISTRAR R. E. F. J. J.	
25C. FUNERAL DIRECTOR Sullivan Funeral Home		ADDRESS 1011-13 N. Arlington Ave	

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WALLACE P. JOHNSON

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-4693

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SOLOMON DAVIS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 4, 1968</b>		Hour <b>1:20 A.</b> M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 4, 1968</b>		Hour <b>1:20 A.</b> M.
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>95, 46</b>		10. AGE (In years) <b>20</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		C. CITY OR TOWN <b>Baltimore</b>
11. BIRTHPLACE (State or foreign country) <b>Iris South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Beatrice Davis</b>		E. STREET AND NUMBER <b>3210 Massachusetts Avenue</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>212-44</b>		18. INFORMANT <b>Beatrice Davis 3210 Massachusetts Ave Baltimore 2928</b>
19. <b>412.41</b> CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				
20. DATE OF OPERATION <b>422.1</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> <b>5-4-68</b>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>May 6, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>William L. Taylor</b>		
25D. ADDRESS <b>2312 W. North Ave Baltimore 16 Md</b>				

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Date  
Time

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WALLACE COLLEGE

WALLACE COLLEGE

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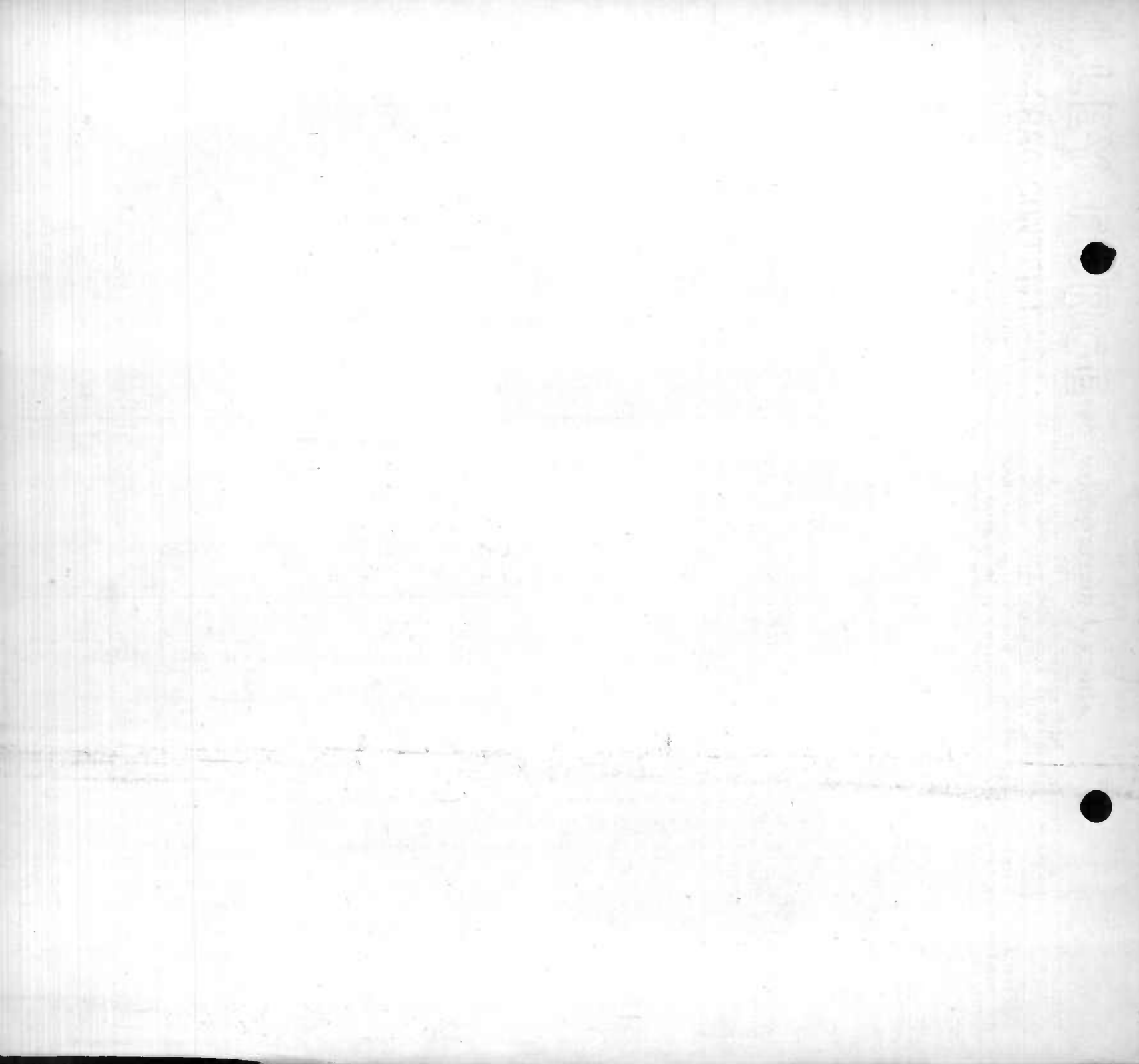
100

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4694
J-525 68-4694		<b>CERTIFICATE OF DEATH</b>		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Oscar Johnson</i>		2. DATE AND HOUR OF DEATH <i>5 3, 68 8:00 P</i> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>343 Spring Court</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>343 Spring Court</i>				
5. SEX <i>male</i>	6. RACE <i>cal</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8 25 1916</i>	9. AGE (In years last birthday) <i>71</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Kansas City Mo</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Owens Johnson</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Johnson 343 Spring Court</i>	
18. <i>410.01</i>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>		
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Thrombosis</i>		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertension</i>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(C) <i>None</i>		
420.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19C. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>9/24/68</i> 19 <i>68</i> to <i>573</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/29</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Albert L. LaForest</i>		23B. DATE SIGNED <i>5/4/68</i>		
23C. PHYSICIAN'S NAME (Type) <i>DR ALBERT L. LAFOREST</i>		23D. ADDRESS <i>822N. Bond ST BALTIMORE MD 21205</i>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>5/7/68</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 6 1968</i>	25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	25C. FUNERAL DIRECTOR <i>Albert L. LaForest</i> ADDRESS <i>2302 W North Ave</i>		





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-163

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4695
68-4695				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Maudie B. Gebhart</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>May 3, 1968</u> <u>5:45</u> <u>PM</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>212/2</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <u>5817 Falkirk Rd.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/1908</u>	9. AGE (In years last birthday) <u>69</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Elisabeth Lutz</u>		14. MOTHER'S MAIDEN NAME <u>Martha B. Rowe</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>MA 705-07-8997</u>		17. INFORMANT <u>Hospital Chart</u>
18. <u>592X</u>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute necrotizing pyelonephritis</u> <u>Urterolithiasis</u> <u>possible</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>gram negative bacteremia</u>		
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>4/29 1968</u> to <u>5/3 1968</u> , that (I) (we) last saw the deceased alive on <u>5/3 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>5/3/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		23D. ADDRESS <u>[Signature]</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 3, '68</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1968</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Eugenia K. Seitz</u>
25D. ADDRESS <u>5200 York Rd. Balto. Md. 21212</u>				

10/15/10

10/15/10

10/15/10

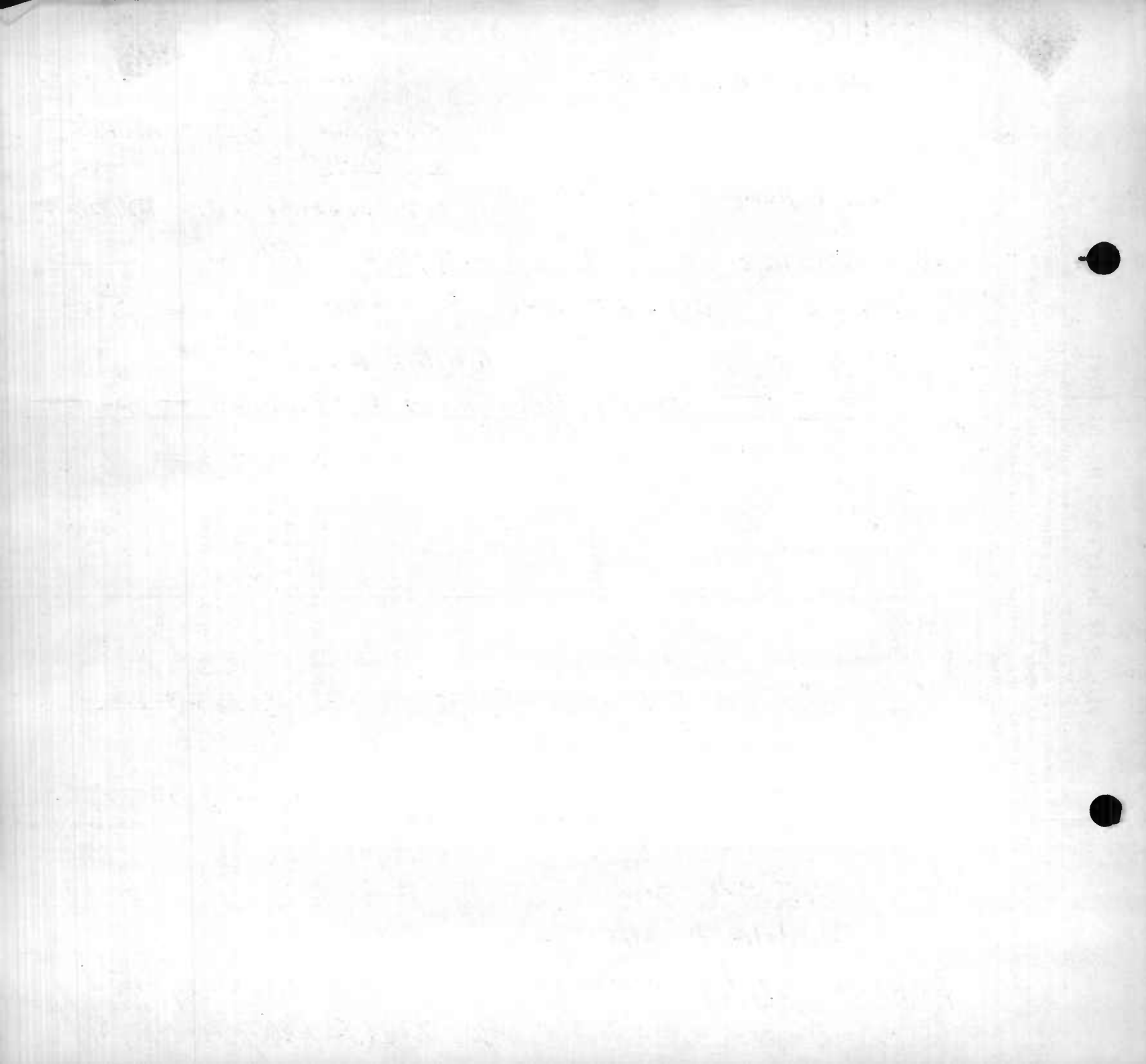
10/15/10

10/15/10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">8 696</span>
<b>G-416</b> <b>68-4696</b> <b>CERTIFICATE OF DEATH</b>		<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>MILO S GILBERT</b>		
<b>2. DATE AND HOUR OF DEATH</b> <b>4-30-68</b> <b>9:30 A.M.</b>		<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>35 Church Home &amp; Hospital</b>		
<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTIMORE</b>		<b>5. CITY OR TOWN</b> <b>DUNDALK</b> <b>Baltimore</b> <b>INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>6. STREET AND NUMBER</b> <b>3135 Baybriar Rd. 21222</b>		<b>7. SEX</b> <b>M</b> <b>8. RACE</b> <b>WHITE</b>		
<b>9. MARIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>10. DATE OF BIRTH</b> <b>12/29/1906</b> <b>9. AGE</b> (In years lost birthday) <b>61</b>		
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>PACKER</b>		<b>12. KIND OF BUSINESS OR INDUSTRY</b> <b>BLDG. MATERIAL</b>		
<b>13. FATHER'S NAME</b> <b>JOHN B.</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>MINNIE L. CARTEE</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>249-07-6062</b>		
<b>17. INFORMANT</b> <b>RILLA B. GILBERT - WIFE</b>		<b>18. CAUSE OF DEATH</b>		
<b>19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>410.9 I</b> <b>Acute Myocardial Infarction</b> <b>few hours</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>year</b>		
<b>20. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>		<b>21. IMMEDIATE CAUSE</b> <b>Acute Myocardial Infarction</b> <b>22. DUE TO, OR AS A CONSEQUENCE OF:</b> <b>ASEVD</b> <b>23. DUE TO, OR AS A CONSEQUENCE OF:</b>		
<b>24. MEDICAL CERTIFICATION</b> <b>19A. DATE OF OPERATION</b> <b>0</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>4-30</b> <b>1968</b> <b>to</b> <b>4-30</b> <b>1968</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>4-30</b> <b>1968</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>4-30</b> <b>1968</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <b>Rodelio M. Lim</b>		<b>23B. DATE SIGNED</b> <b>4-30-68</b>		
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Rodelio M. Lim</b>		<b>23D. ADDRESS</b> <b>CHH</b>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>24B. DATE</b> <b>5/6/68</b>		
<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>OAK LAWN</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>BALTO. CO., Md.</b>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 6 1968</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Fairburn</b>		
<b>25C. FUNERAL DIRECTOR</b> <b>W. Burke Bradley, Hurdell, Md.</b>		<b>25D. ADDRESS</b>		



m-255

68-4697

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68-4697

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

David McMayhann

2. DATE AND HOUR OF DEATH

5/2/68

11:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

7856 Gough Street

21224

5. SEX

Male

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

4-30-1887

9. AGE (In years  
lost birthday)

87

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

MACHINIST

10B. KIND OF BUSINESS OR INDUSTRY

RAILROAD

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNK.

14. MOTHER'S MAIDEN NAME

UNK.

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

713/09/5864

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

410.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC ARREST

(B) DUE TO, OR AS A CONSEQUENCE OF:

Acute MI

(C) DUE TO, OR AS A CONSEQUENCE OF:

Diffuse Pulmonary Infiltrate &amp; Anoxia.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/28 1968 to 5/2 1968,  
that (I) (we) lost saw the deceased alive on 5/2 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Kay E. Gilman, M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

5/2/68

23C. PHYSICIAN'S  
NAME (Type)

KAY E. Gilman, M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore,  
Baltimore City Hospitals Md.24A. BURIAL CREATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

5/6/68

24C. NAME OF CEMETERY OR CREMATORY

CLAY TOWNSHIP

24D. LOCATION

(City, town, or county)

(State)

GENOA, OHIO

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAY 6 1968

Robert E. Jackson

Arthur Buckley, D.D., M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CARDIAC ARREST

ACUTE MI

Distal Arterial Int. Ulcer & Spasm

NEZ

2/5

2/5

4/58  
2/5

2/5

2/5

2/5

2/5

Kay E. Gilman, M.D.

Kay E. Gilman, M.D.

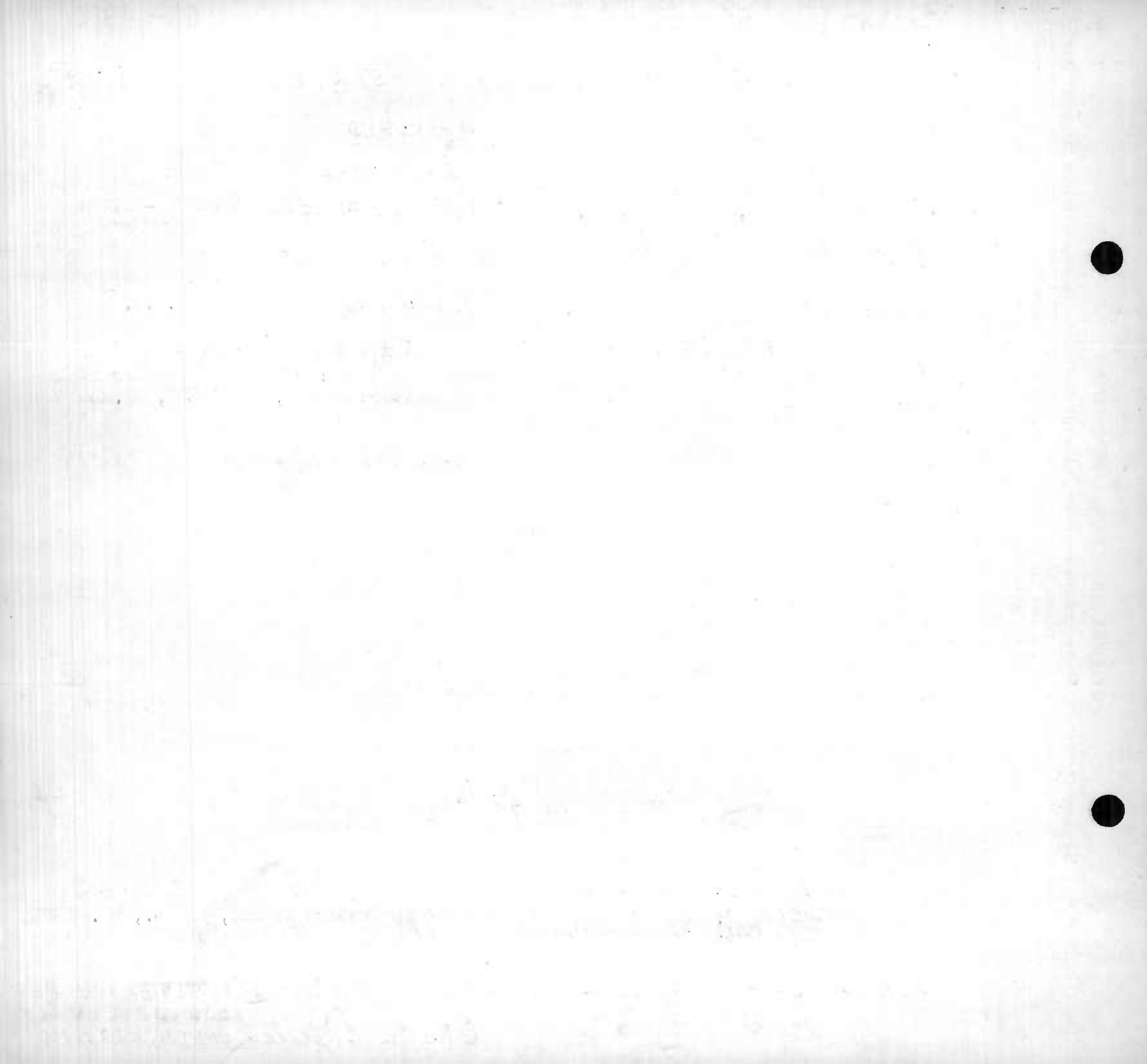
Baltimore City Hospital



# FUNERAL DIRECTOR: IMPORTANT

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43-45-191 IW		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4698	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DOROTHY MAE BROOKS DOROTHY Mae BROOKS.		5/2/68. 10:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
31 BALTIMORE CITY HOSP. 4940 Eastern Avenue, Baltimore, Md. 21224				MARYLAND.	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				5315 REMMELL AVENUE - 21206	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
HOUSEWORK		AT HOME		8-3-02	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
BENJAMIN F. LAIRD		SARAH E. REVELL		65	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?	
No				U.S.A.	
17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224				11 Under 1 Yr. Months Days	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				1 week.	
ANTECEDENT CAUSES				2 years.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				BRAIN STEM HEMORRHAGE.	
19A. DATE OF OPERATION				(B) ASCVD.	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				DUE TO, OR AS A CONSEQUENCE OF:	
20A. AUTOPSY? (Yes or No)				(C).....	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/30/68 to 5/2/68, that (I) (we) last saw the deceased alive on 5/2/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
GRACIELA S. ALARCON				5/2/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
GRACIELA S. ALARCON				4940 Eastern Avenue, Balto., Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
BURIAL				5-6-68	
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
LOMBARDY CEM.				NEW CASTLE CO., WILMINGTON, DEL.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 6 1968		R. E. Fidler		Charles S. Jailer	
VS 150-REV. 1/1/68				6224 EASTERN AVE. BALTO., 21224, MD.	



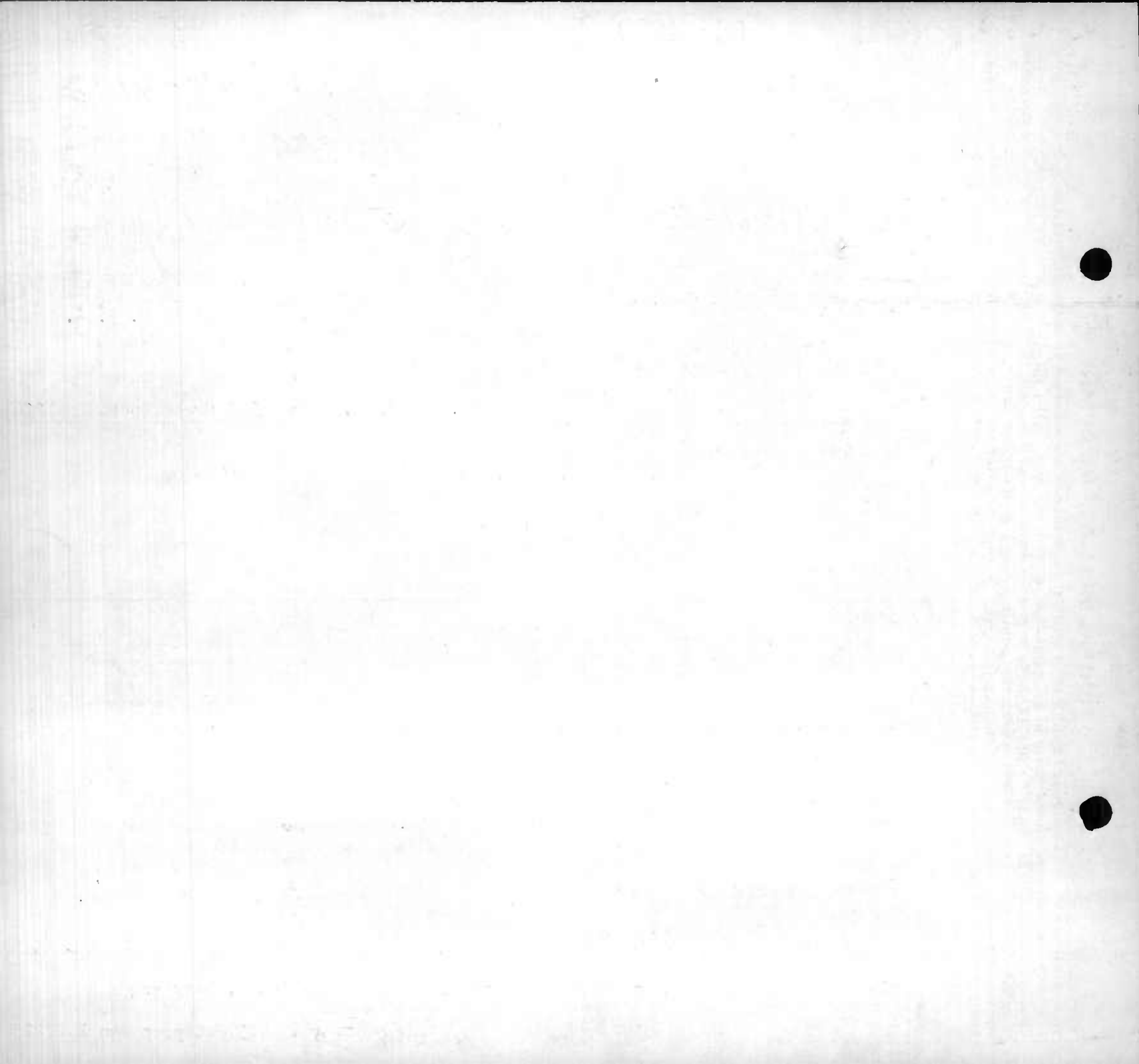
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4699 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

68- 4699 REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HENRIETTA W. KERN</b>		2. DATE AND HOUR OF DEATH <b>5-2-1968 12:40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>G.A.C. 52-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hosp.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Pasadena</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>8415 Bedford Rd.</b>		5. SEX <b>F</b> 6. RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2-8-88</b>		9. AGE (In years last birthday) <b>80</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Henry Kuhlman</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Leslie E. Kern 4103 Grace Court 21226</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE (2) Lower Lobe Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C) Dehydration</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II Past history M.I.</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>4-28 1968</b> to <b>5-2 1968</b> , that (we) last saw the deceased alive on <b>5-2 1968</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>Donald M. Wood</b>		DEGREE <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-2-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Donald M. Wood, M.D.</b>		DEGREE		23D. ADDRESS <b>South Baltimore General Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>McElly F. H.</b>	
25D. ADDRESS <b>237 Patapsco Ave</b>		25E. <b>21225</b>			



# FUNERAL DIRECTOR: IMPORTANT

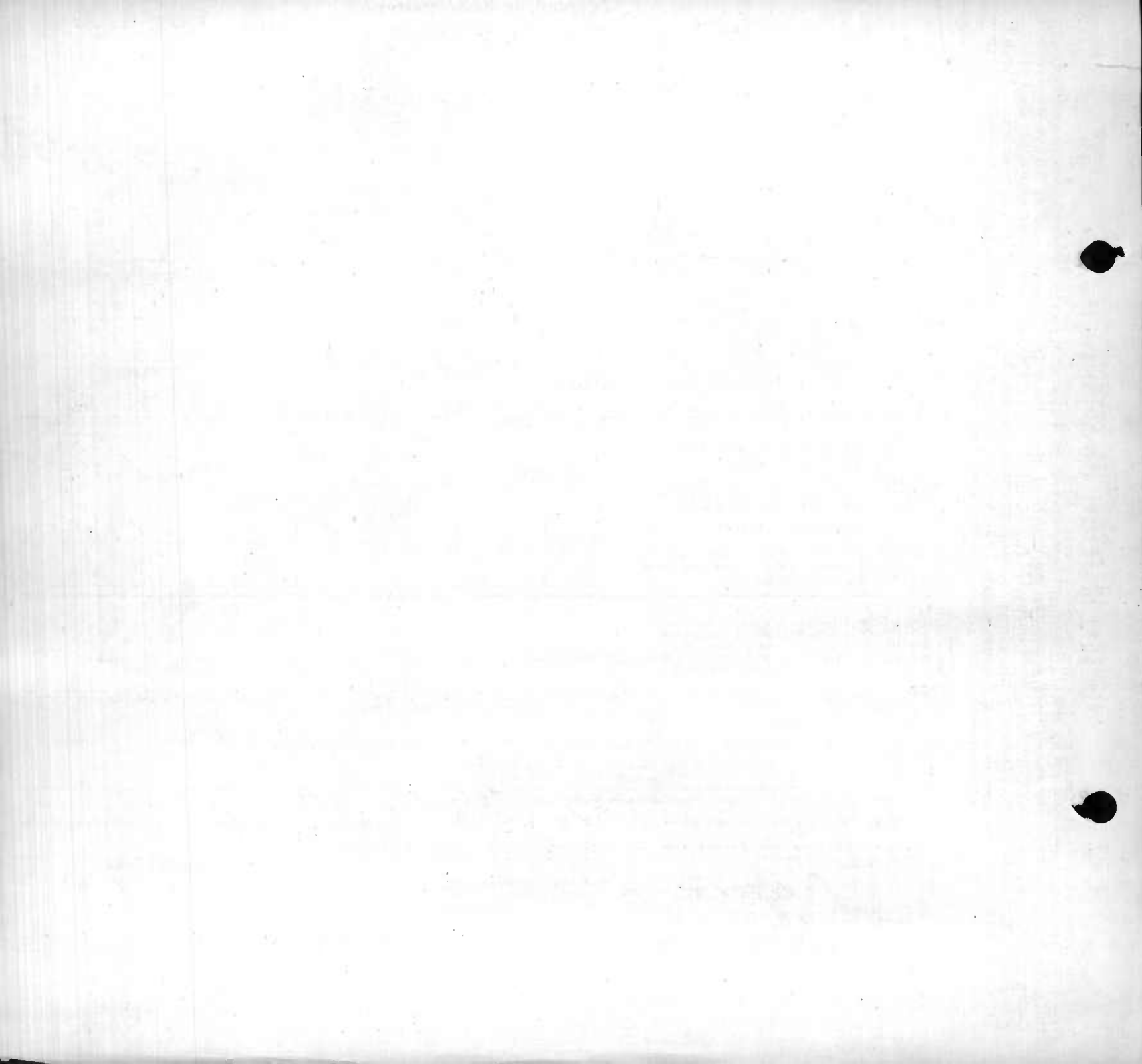
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4700

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 4700

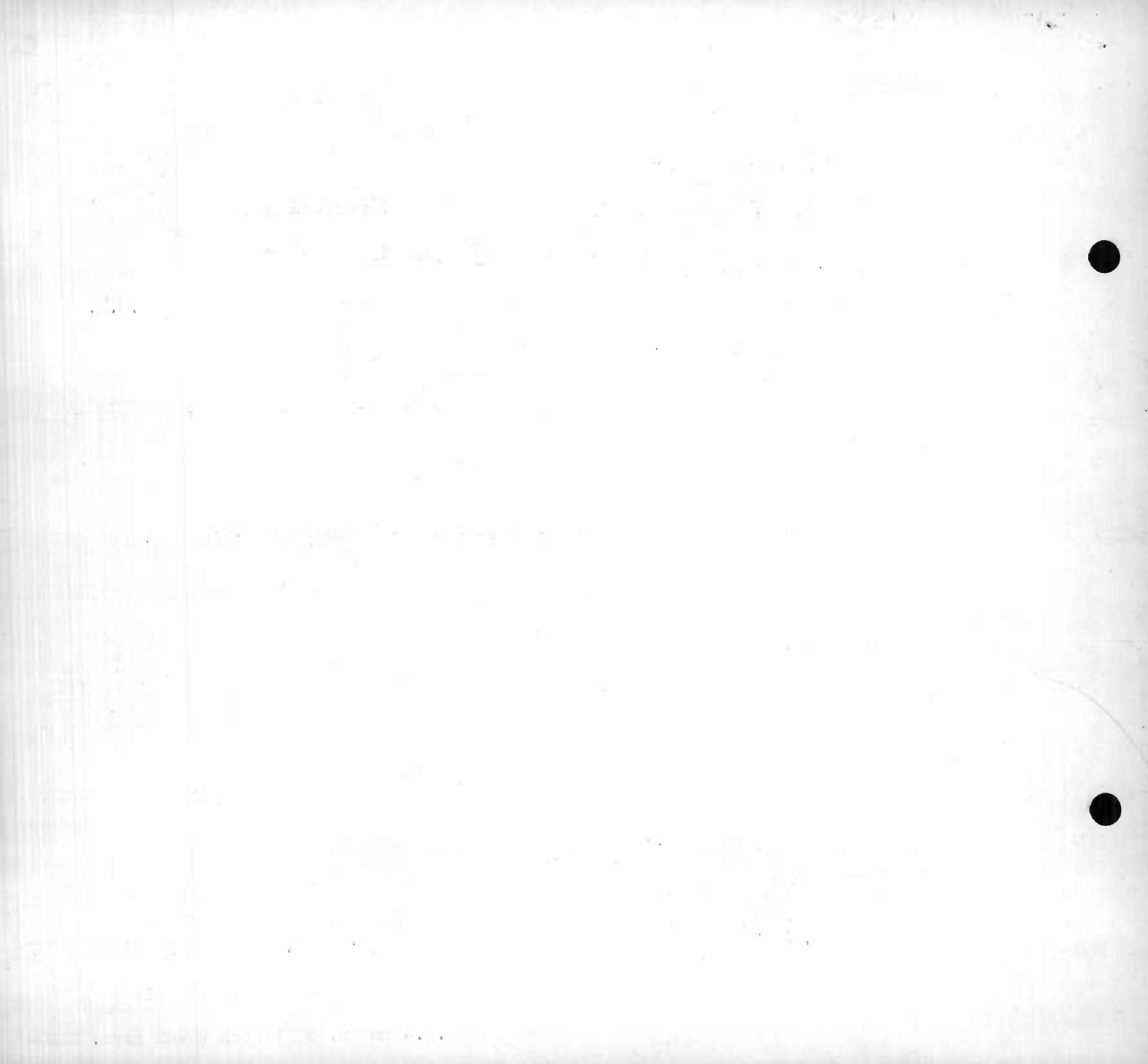
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>JOHN N. MOORE</i>		2. DATE AND HOUR OF DEATH <i>5/4/1968</i> <i>1:15</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University Shop.</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind.</i> B. COUNTY	
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Recordkeeping, Values</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Pige Co.</i>		8. DATE OF BIRTH <i>Sept 3, 1905</i>	
13. FATHER'S NAME <i>Clarence W. Moore</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Amos</i>		9. AGE (In years last birthday) <i>62</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-01-7938</i>		17. INFORMANT <i>Mr. Judy Green</i>	
18. <i>410.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i> (B) <i>See Above</i> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>1 year</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>420.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 1</i> 19 <i>06</i> to <i>5/4/68</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>5/4/68</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>S. MURKES, M.D.</i>				23B. DATE SIGNED <i>5/4/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>888 W. LOMBARD ST. BALTIMORE, MD. 21201</i>				23D. ADDRESS <i>888 W. Lombard St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>5/7/1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Int. Aline Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 6 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>		25C. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son, Inc. 901 Hollins St. Balt. Ind. 21223</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4701	
BIRTH NO. N-250		68-4701		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Orville William Nixon</b>			2. DATE AND HOUR OF DEATH <b>4/30/68 1:25 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>			C. CITY OR TOWN <b>Balto</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>7811 Jamesford Road 21222</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-20-12</b>	9. AGE (In years lost in day) <b>55</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Robert Nixon</b>			14. MOTHER'S MAIDEN NAME <b>Maggie Colyer</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>228 07 01 01</b>		16. SOCIAL SECURITY NO. <b>228 07 01 01</b>	17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>		
18. <b>400.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <b>Choked</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Malignant Hypertension</b> <b>(C)</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
19. <b>445X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>3/12</b> 19 <b>68</b> to <b>4/30</b> 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>4/30</b> 19 <b>68</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Jaffe, M.D.</b>			23B. DATE SIGNED <b>4/30/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>M. Jaffe</b>			23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>5-1-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Coeburn, Virginia</b>	
24D. LOCATION (City, town, or county) (State) <b>Coeburn, Virginia</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
25C. FUNERAL DIRECTOR <b>Wm. E. Johnson</b>		25D. ADDRESS <b>8521 Loch Raven Blvd. 21204</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">BALTIMORE CITY HEALTH DEPARTMENT</span>				68- 4702 <b>CERTIFICATE OF DEATH</b>		REG. NO. <span style="float: right;">68- 4702</span>	
1. NAME OF DECEASED (Type or Print) <b>Sister Josephine Reilly</b>				2. DATE AND HOUR OF DEATH <b>May 3, 1968 - 4:05 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>93 Villa Saint Michael 4000 Forest Hill Road</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>0000</b> C. CITY OR TOWN <b>Baltimore City</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4000 Forest Hill Road, 21207</b>			
5. SEX <b>F.</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-26-1893</b>		9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher (retired)</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Sister of Charity</b>		11. BIRTHPLACE (State or foreign country) <b>Albany, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>Charles Reilly</b>				14. MOTHER'S MAIDEN NAME <b>Delia Lawson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Doubtful</b>			16. SOCIAL SECURITY NO. <b>250-80-7468</b>		17. INFORMANT ADDRESS <b>Jl. Sister Andrea - same address</b>		
18. CAUSE OF DEATH <b>710.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary occlusion</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Abdominal Aneurysm</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>  <b>?</b> <b>10 years</b>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 23, 1968</b> to <b>May 3, 1968</b> that (I) (we) last saw the deceased alive on <b>May April 30, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>No</b>							
23A. SIGNATURE <i>Samuel P. Plogra</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>May 3, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>3326 Frederick Avenue</b>				23D. ADDRESS <b>3326 Frederick Avenue, Baltimore, 21228</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>May 6, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Seton Inst. Cemetery -</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO.,</b>		ADDRESS <b>108 W. North Av., City</b>	

James M. Taylor

# FUNERAL DIRECTOR: IMPORTANT

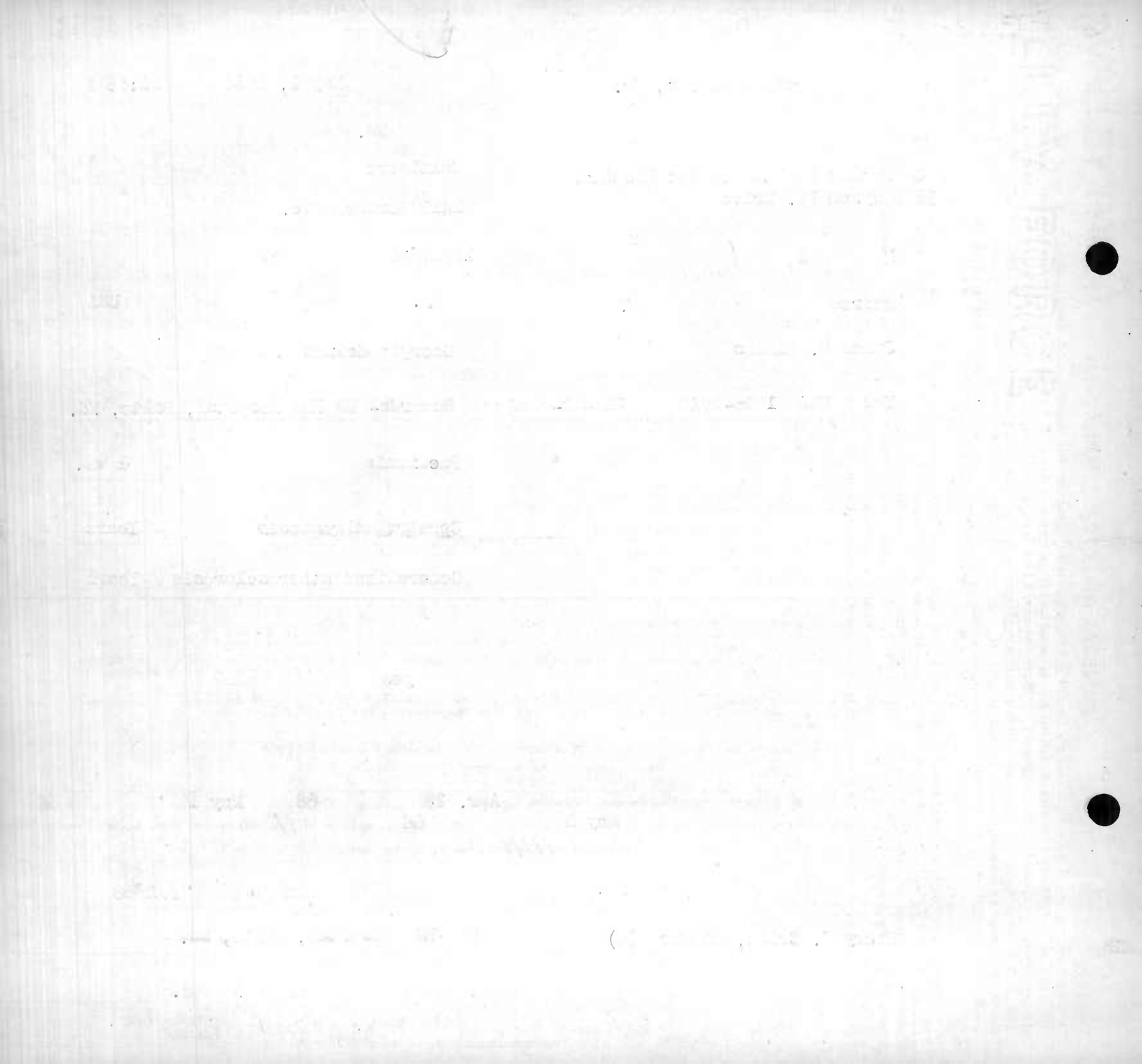
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4703

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 4703

BIRTH NO. <span style="float: right;">425</span>		1. NAME OF DECEASED (Type or Print) <b>Dennie Elkins, Sr.</b>		2. DATE AND HOUR OF DEATH <b>May 1, 1968 11:58 P</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Pk. Drive</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY  C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <span style="float: right;">9-05</span>		E. STREET AND NUMBER <b>1412 Gorsuch Ave.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/17/86</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>USA</b>		11. BIRTHPLACE (State or foreign country) <b>Ky.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James W. Elkins</b>		14. MOTHER'S MAIDEN NAME <b>Georgia <del>James</del> Caines</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes USA 1916-1940</b>		16. SOCIAL SECURITY NO. <b>218-22-0164</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>	
18. <b>733.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral thrombosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Generalized atherosclerosis</b>		<b>Years</b>	
(C) <b>Generalized atherosclerosis</b>		<b>Years</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A). <b>332X II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>Apr. 29</b> 19 <b>68</b> to <b>May 1</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>May 1</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Henry S. Crist, M.D.</i>		23B. DATE SIGNED <b>5/2/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Henry S. Crist, SA Surg (R)</b>	
23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>		24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24A. DATE <b>5/6/68</b>		24B. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		24C. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4704

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4704

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HAZEL ROE WALKER</b>		2. DATE AND HOUR OF DEATH <b>May 1, 1968 11:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>5811 Hillen Road</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-28-95</b>	9. AGE (In years lost birthday) <b>72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>WILLIAM ROE</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH WARD</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-6427</b>		17. INFORMANT <b>Malcolm C. Walker Balto. Md. 21212</b>	
18. <b>5-7-7, 0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) <b>Acute leukemia having metastasized</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute leukemia having metastasized</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unk.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF:			
(C) <b>Alcoholism</b>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>5-8-7, 0 II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 15, 1968</b> to <b>May 15, 1968</b> , that (I) (we) last saw the deceased alive on <b>May 15, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>May 15, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>MIGUEL SANCHEZ-PALACIOS</b> <b>MIGUEL SANCHEZ = PALACIOS MD.</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b> <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/4/1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Centre</b>	
24D. LOCATION (City, town, or county) (State) <b>Forest Hill, Harford, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		24F. NAME OF REGISTRAR <b>[Signature]</b>	
24G. FUNERAL DIRECTOR <b>Charles E. Kurtz</b>		24H. ADDRESS <b>Jarrettsville, Md.</b>			

X

MARYLAND

BALTIMORE

2811 Miller Road

12-28-92 25

MARYLAND

ELIZABETH WARD

UNION MEMORIAL HOSPITAL

X

W

F

WILLIAM ROE

*At the time of the [redacted]  
[redacted]  
[redacted]*

Yes

May 12 08

May 12 08

May 12 08

*W. J. [redacted]*

UNION MEMORIAL HOSPITAL

UNION MEMORIAL HOSPITAL

X

2811 MILLER ROAD

2811 MILLER ROAD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**CERTIFICATE AMENDED** 5/14/68

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4705	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>John H. Lutz</u>		2. DATE AND HOUR OF DEATH <u>5-1-68</u> <u>7:45 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Franklin Square Hosp</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Franklin Square Hosp</u>			C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <u>719 N. MILTON Ave</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-10-1921</u>		9. AGE (In years last birthday) <u>46</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Produce</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>William Lutz</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Seifert</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-40-4336</u>		17. INFORMANT <u>Lang Buchholz</u> ADDRESS <u>F.S. 1</u>	
18. <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>443X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CHF &amp; EVA</u> (B) <u>M.A.S. &amp; EVA</u> (C) _____		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-7</u> 19 <u>68</u> to <u>5-1</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-1</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lang Buchholz</u> M.D. DEGREE				23B. DATE SIGNED <u>5-1</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lang Buchholz</u> M.D. DEGREE				23D. ADDRESS <u>Franklin Square Hosp</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-1-1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore City Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR ADDRESS <u>21236 Lassahn Funeral Home 7401 Belair Road</u>	

5/10/68 - Correction form from funeral director

*[Signature]*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		68- 4706		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 4706	
1. NAME OF DECEASED (Type or Print) <b>PALASIK, George A</b>				2. DATE AND HOUR OF DEATH <b>5-3-68</b> <b>10:10 P</b> M.			
3. PLACE IN <b>BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>114 South Broadway</b>			
5. SEX <b>Male</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-25-93</b>	9. AGE (In years lost birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank Palasik</b> (232-26-8907)				14. MOTHER'S MAIDEN NAME <b>Mary Wisniewska</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>2-23-18 to 6-6-19</b>		16. SOCIAL SECURITY NO. <b>361-03-25-93</b>		17. INFORMANT <b>VA Hospital Records</b> ADDRESS <b>3900 Loch Raven Blvd., Balto, Md 21218</b>			
18. <b>4124 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchopneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Atherosclerotic Cardiovascular Disease</b> (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Weeks</b> <b>1 Month</b> <b>20 Years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>422.1 II Dehydration and Malnutrition</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 26,</b> 19 <b>68</b> to <b>May 3,</b> 19 <b>68</b> , that <b>I</b> (we) last saw the deceased alive on <b>May 3,</b> 19 <b>68</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>I</b> (We) (did) <b>(initials)</b> view the body after death.							
23A. SIGNATURE <b>Gordon F. Murray</b> DEGREE						23B. DATE SIGNED <b>May 4, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>GORDON F. MURRAY</b>		23D. ADDRESS <b>M.D. Veterans Administration Hospital, Balto, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/7/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>G. E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>			

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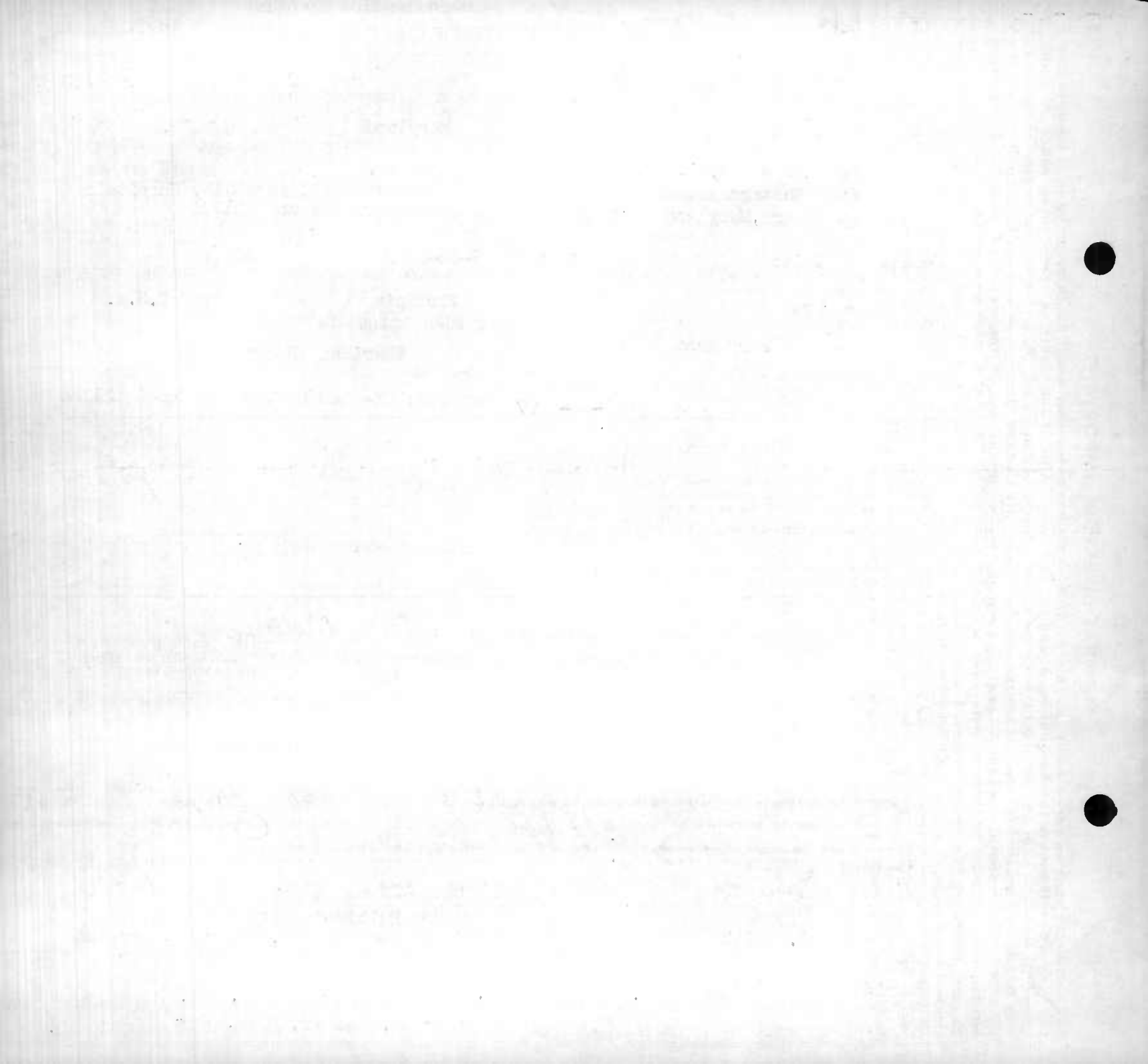
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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-160		68-4707		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4707	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>ANNA MOUNBRAY</b>			
2. DATE AND HOUR OF DEATH <b>May 2, 1968</b> <b>3:15 A.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>3/ Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue, 21224</b>			
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-16-1883</b>	
9. AGE (In years last birthday) <b>85</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Henry Kent</b>			
14. MOTHER'S MAIDEN NAME <b>Clarissa Burgess</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>219-32-3377</b>				17. INFORMANT <b>Records: BCH-4940 Eastern Avenue 21224</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Chronic Pyelonephritis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: <b>Severe ARTERIOSCLEROSIS - dissection</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>600.0 II</b>				20. DATE OF OPERATION <b>D</b>			
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
23. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
25. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				26. HOW DID INJURY OCCUR?			
27. I certify that (I) (this hospital) attended the deceased from <b>Feb 3</b> 19 <b>67</b> to <b>May 2</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5/2/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				28. DATE SIGNED <b>5/2/68</b>			
29. SIGNATURE <b>Ron E. Smith</b>				30. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue, Baltimore, Maryland</b>			
31. PHYSICIAN'S NAME (Type) <b>Ron E. Smith</b>				32. DATE <b>5/6/68</b>			
33. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				34. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet Cem.</b>			
35. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>				36. NAME OF REGISTRAR <b>John E. Jackson</b>			
37. FUNERAL DIRECTOR <b>JOHN F. DENNY, INC.</b>				38. ADDRESS <b>715 Light St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

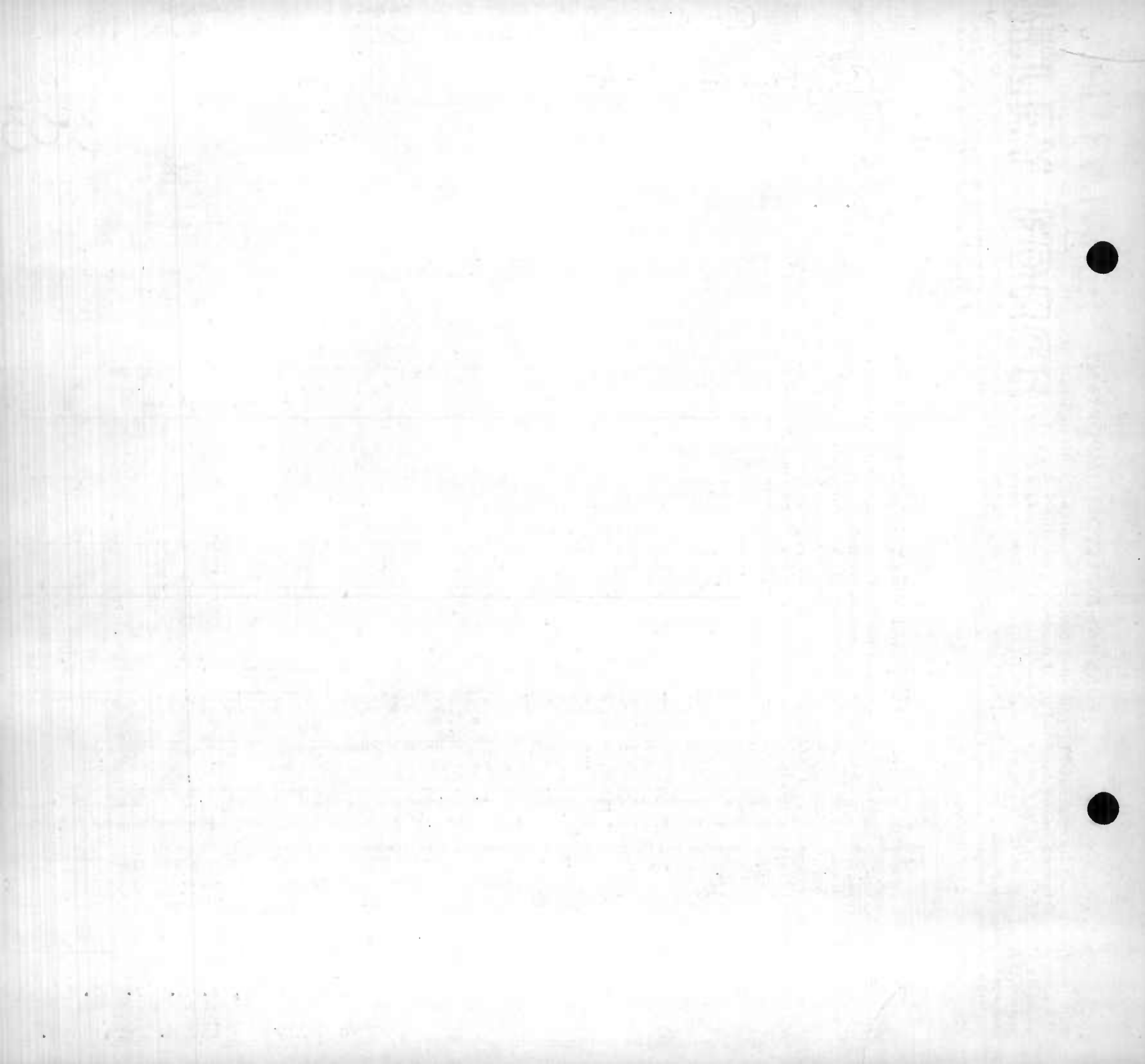
68- 4708

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 4708

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Biagtan Andrew</b>		2. DATE AND HOUR OF DEATH <b>5/4/68</b> <b>16<sup>50</sup></b> P.M.	
3. PLACE IN <b>BALTIMORE, MARYLAND</b> , WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>Balto</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>2X U. S. Public Health Hospital</b>			C. CITY OR TOWN <b>Balto</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M</b> 6. RACE <b>Filipino</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/13/11</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Seaman</b>		9. AGE (In years last birthday) <b>57</b>
13. FATHER'S NAME <b>Isidro Biagtan</b>			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>577 12 9637</b>		17. INFORMANT <b>P. P. Guder M.D. Hospital</b>
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarct</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/16</b> <b>1968</b> to <b>5/4</b> <b>1968</b> , that (I) (we) last saw the deceased alive on <b>5/4</b> <b>1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Peter P. Guder M.D.</b>				23B. DATE SIGNED <b>5/5/68</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>USPHS Hospital Balto</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5 7 68</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, A. A. Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Tabor</b>		25C. FUNERAL DIRECTOR <b>Mc Cully</b>			
25D. ADDRESS <b>130 E. Fort Ave.</b>					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																													
68- 4709					REG. NO. 68- 4709																								
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <i>Miss SARA B. SHULTZ</i>					2. DATE AND HOUR OF DEATH <i>5-1-68 5<sup>20</sup> P. M.</i>																			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD										4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>-</i>																			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Md. General Hosp</i>										C. CITY OR TOWN <i>BALTO</i>					D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
										E. STREET AND NUMBER <i>2211 W Rogers Ave</i>																			
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-25-77</i>		9. AGE (In years lost birthday) <i>91</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.																	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>					11. BIRTHPLACE (State or foreign country) <i>Md.</i>					12. CITIZEN OF WHAT COUNTRY? <i>USA</i>														
13. FATHER'S NAME <i>JOHN A SHULTZ</i>					14. MOTHER'S MAIDEN NAME <i>CROOKS, Henrietta</i>					15. Was Deceased Ever in U. S. Armed Forces? (Yes, or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>216104900A</i>														
										17. INFORMANT <i>Mrs Ross</i>					ADDRESS <i>Same</i>														
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>ASCUD</i>										(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>														
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Pneumonia</i>										(B) DUE TO, OR AS A CONSEQUENCE OF: <i>CHF</i>					(C) <i>1 MONTH</i>														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>420.1 II</i>										19A. DATE OF OPERATION <i>NONE</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>					20A. AUTOPSY? (Yes or No) <i>Yes</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <i>NO</i>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i>																			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <i>-</i>					21F. HOW DID INJURY OCCUR? <i>-</i>																			
22. I certify that (I) (this hospital) attended the deceased from <i>4/5/68</i> 19 <i>68</i> to <i>5/1</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5/1</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																													
23A. SIGNATURE <i>F. J. ZORICK MD</i>										Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <i>5-1-68</i>														
23C. PHYSICIAN'S NAME (Type) <i>F. J. ZORICK MD</i>										23D. ADDRESS <i>Md Gen'l Hosp BALTO</i>																			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>					24B. DATE <i>5-4-68</i>					24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cem</i>					24D. LOCATION (City, town, or county) (State) <i>Pikesville Balto Co Md</i>														
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 6 1968</i>					25B. NAME OF REGISTRAR <i>Robert E. Farber</i>					25C. FUNERAL DIRECTOR <i>Burgess Funeral Home Balto Md</i>																			
										ADDRESS <i>By Nina Whisman, Jr.</i>																			

Mr. General

F W

John A 2/1/15  
none

Mr. General

8-32-17 21

Mr.

CROOKS

Mrs. Ross

ASCHUD

CHF

452

none

no

10

2/1

1/28

18

0

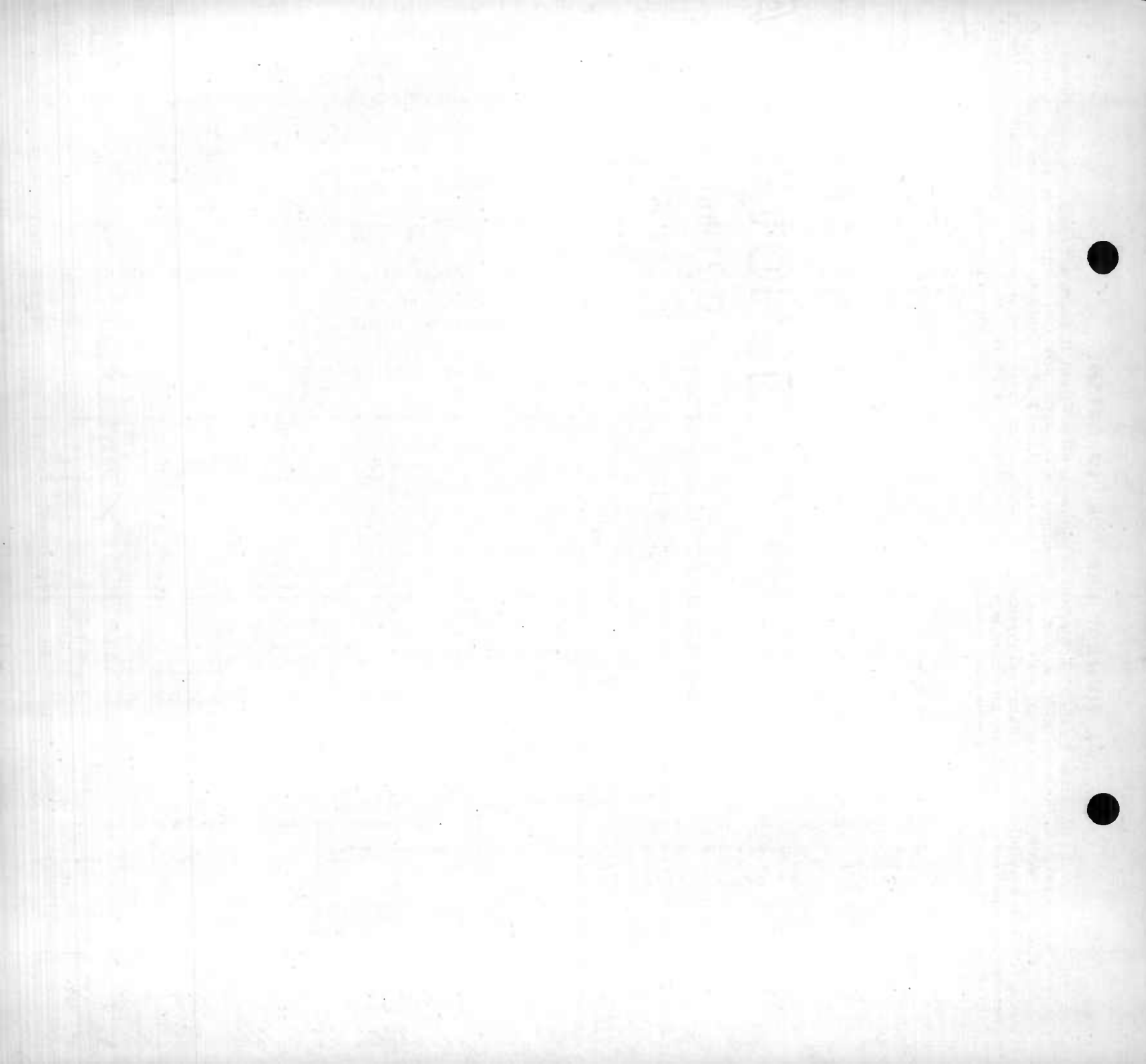
2/1

F. J. FORBICK MD  
2-1-15

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
68- 4710		68- 4710		5-2-68	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Cecilia Fidelis Easter		5-2-68		5:55 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Montebello State Hospital			Md. Baltimore		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			6209 Reisterstown Rd.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	4-25-1898	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Sales lady		Pikesville 5410		Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Frank Hayden			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Unknown		217-07-3253		Hospital Chart	
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Bilateral Pneumonia 2 weeks		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,			(B) Cause unknown — DUE TO, OR AS A CONSEQUENCE OF:		
			(C) —————		
490X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Right C.V.A. with left hemiparesis		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (In only medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At <input type="checkbox"/> Not While <input type="checkbox"/>			
		Work <input type="checkbox"/> AT Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2-20-1968 to 5-2-1968, that (I) (we) last saw the deceased alive on 5-2-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Cesar J. Pellerano M.D.				5-2-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Cesar J. Pellerano M.D.				Montebello Hospital	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		MAY 6 1968		London Park Cemetery Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 6 1968		Robert E. Fisher		Frank H. Newell, Salesville 82nd	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DAVID BERNARD UDOFF</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sinai Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 1, 1968 6:10 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>California</b> B. COUNTY			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Lakewood</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>JAN. 4, 1912</b>	10. AGE (In years lost birthday) <b>56</b>	E. STREET AND NUMBER <b>3729 Arbor Road V-04</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROPRIETOR</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>DRAPERY &amp; GIFT STORE</b>	
15. MOTHER'S MAIDEN NAME <b>LENA ?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>MRS. ROSLYNE UDOFF, 3729 ARBOR ROAD, LAKEWOOD, CALIFORNIA</b>	
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>422.1 II</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>May 2, 1968</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL-BURIAL</b>		24B. DATE <b>5-3-68</b>	
24C. NAME of CEMETERY or CREMATORY <b>HOME OF PEACE</b>		24D. LOCATION (City, town, or county) (State) <b>LOS ANGELES, CALIFORNIA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Hubert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD, BALTO. 21215</b>	

UNITED STATES  
DEPARTMENT OF JUSTICE

Washington, D.C.

(Room)

Special Agent in Charge

Enclosed

Letter

File

3729 Labor Hall

cc

Jan 4, 1912

ALEXANDER BUCK

U.S.A.

BELT AND WOODLAND

LINE

REARVIEW & GOLF DRIVE

RECEPTION

REARVIEW & GOLF DRIVE, 3729 LABOR HALL,  
WASHINGTON, D.C.

Administrative and General Division

WIA LITELY

MAILED

RECEIVED

X

May 7, 1912

Division of Investigation, D.C.

REARVIEW & GOLF DRIVE

REARVIEW & GOLF DRIVE

REARVIEW & GOLF DRIVE

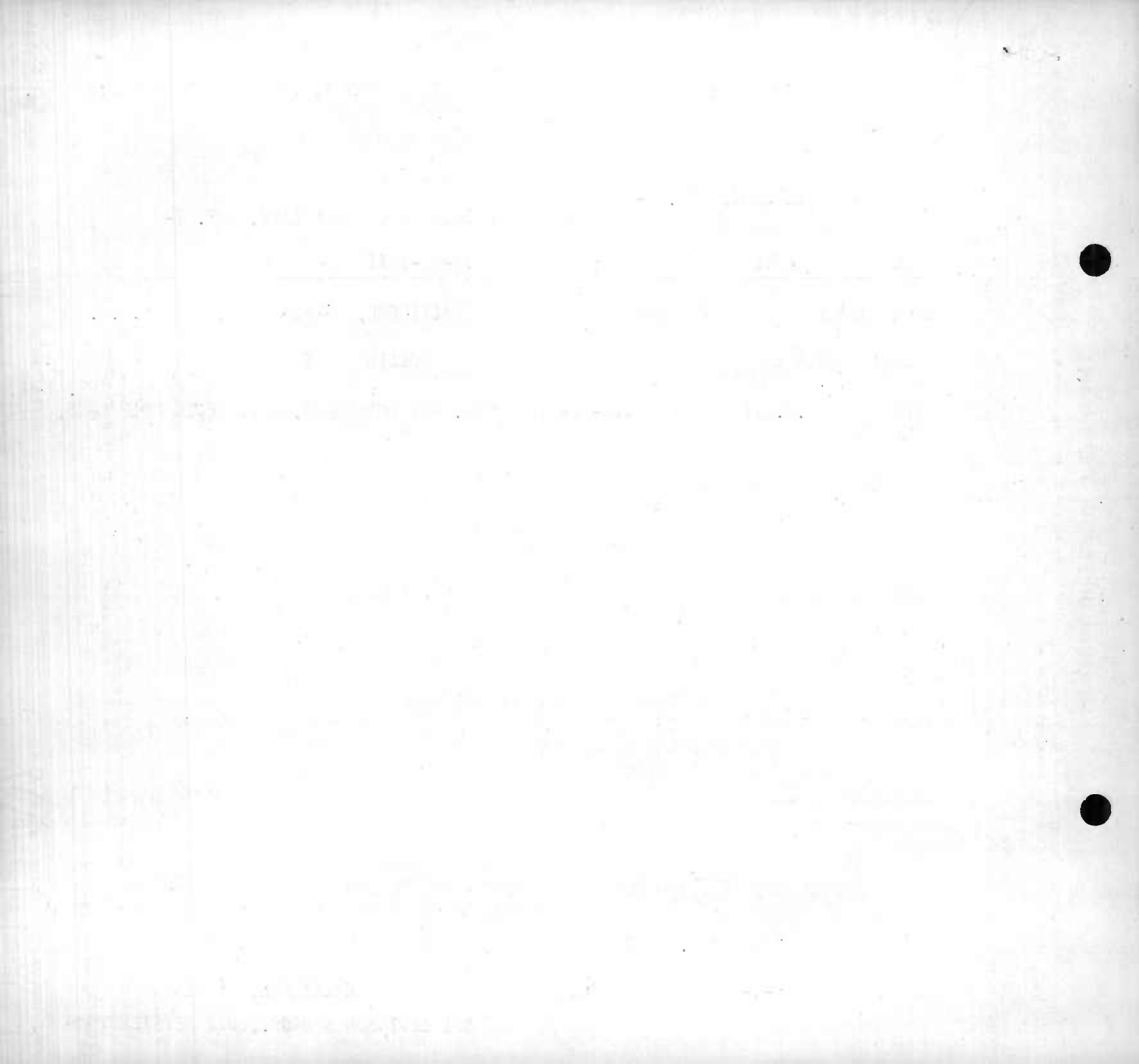
REARVIEW & GOLF DRIVE, 3729 LABOR HALL,  
WASHINGTON, D.C.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-291		68- 4712		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 4712	
1. NAME OF DECEASED (Type or Print) <b>IRVING ROSENBERG</b>				2. DATE AND HOUR OF DEATH <b>MAY 1, 1968</b> <b>3:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3623 SEVEN MILE LANE, APT. T-G</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3623 SEVEN MILE LANE, APT. T-G</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-26-1911</b>	9. AGE (In years lost birthday) <b>56</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FLOOR MANAGER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PARISER BAKERY</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS ROSENBERG</b>				14. MOTHER'S MAIDEN NAME <b>MOLLIE ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W.W. II 214-03-5130</b>		17. INFORMANT <b>MRS. FAY ROSENBERG, 3623 SEVEN MILE LANE, APT. T-G</b>			
18. I <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>162.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION <b>162.1 II</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  20A. AUTOPSY? (Yes or No)  20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				CAUSE OF DEATH <b>D. diffuse metastatic disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Several months</b> (B) <b>Bronchogenic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Several months</b> (C) _____			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22. I certify that (I) (this hospital) attended the deceased from <b>1961</b> to <b>May 1</b> 19 <b>68</b> . that (I) (we) last saw the deceased alive on <b>May 1</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Seymour H. Rubin</b>				23B. DATE SIGNED <b>5/1/68</b>		23C. PHYSICIAN'S NAME (Type) <b>SEYMOUR H. RUBIN</b>	
23D. ADDRESS <b>5415 PARK HEIGHTS AVENUE</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>5-2-68</b>				24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE HEBREW</b>			
24D. LOCATION <b>REISTERSTOWN, BALTIMORE, MARYLAND</b>				25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>				25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>68- 4713</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.2em;">68- 4713</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LEVY, LOUIS.</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">5/1/68</span> <span style="font-size: 1.2em;">8:45 P</span> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Sinai Hospital</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <span style="font-size: 1.2em;">28-02</span> E. STREET AND NUMBER <span style="font-size: 1.2em;">3300 BOWERS AVE. #7</span>	
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">8-10-1896</span>
9. AGE (In years lost birthday) <span style="font-size: 1.2em;">71</span>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Bookkeeper</span>
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Poland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Joseph Levy</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Jennie ?</span>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes WW I</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-03-3864A</span>	
17. INFORMANT <span style="font-size: 1.2em;">Mrs Minnie Levy, 90 Raymond Levy</span>		ADDRESS <span style="font-size: 1.2em;">3735 Parkfield Road</span>	
18. CAUSE OF DEATH I <span style="font-size: 1.2em;">4/1/68</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II <span style="font-size: 1.2em;">4/20.1</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">ACUTE CORONARY INSUFFICIENCY. SEVERE.</span> (B) <span style="font-size: 1.2em;">ATHEROSCLEROTIC CARDIO-VASCULAR DISEASE.</span> (C)	
19A. DATE OF OPERATION <span style="font-size: 1.2em;">4/20.1</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">4/26/68</span> 19 to <span style="font-size: 1.2em;">5/1/68</span> 19, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5/1/68</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">B. Ettinger</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">5/1/68</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">B. Ettinger</span>		23D. ADDRESS <span style="font-size: 1.2em;">Sinai Hospital</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>	24B. DATE <span style="font-size: 1.2em;">5-2-68</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">HAR Zion Tifereth Israel</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Rosedale, Maryland</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 6 1968</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">R. E. Johnson</span>	25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Sol Levinson &amp; Bros, 6010 Reist. Rd.</span>	

Harry Lamb

Baltimore

3300 Bowers St

8-10-1894 71

Toland

Gennie

Mr. Minnie Lamb (Harry's wife)  
3300 Bowers St

State Hospital

White White

Bookkeeper, Commercial

Joseph Levy

Yes WVI

Bethesda State Hospital

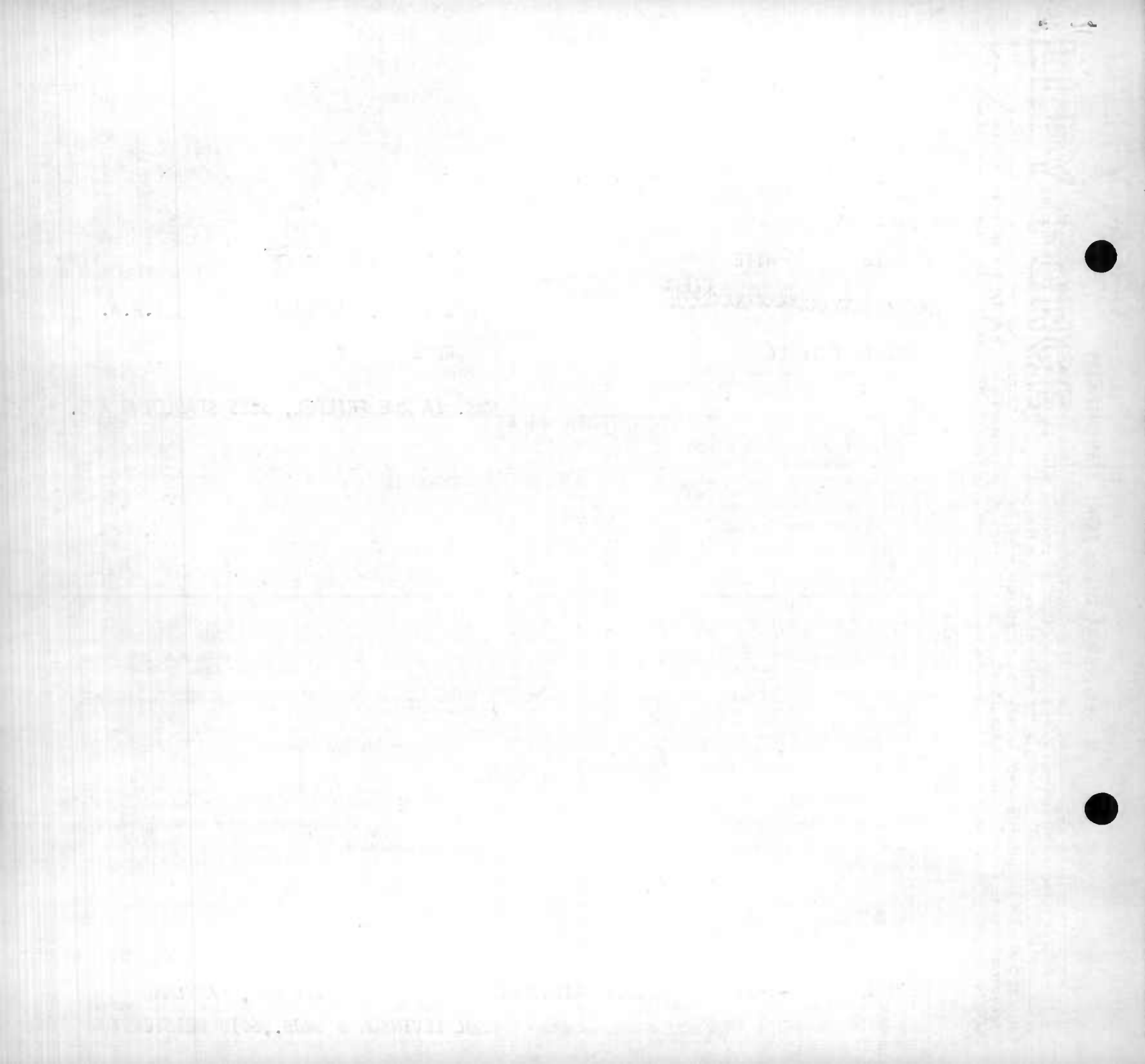
Burial at Mount Hope Cemetery, Baltimore

Dr. J. H. Johnson

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
F-634 68-4714				68-4714	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Irvin Friedel</u>				May 2 1968 11:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Baltimore</u>				A. STATE <u>MD</u> B. COUNTY	
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>				8. DATE OF BIRTH <u>12/4/1899</u> 9. AGE (In years last birthday) <u>68</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>Race Track</u>				11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME <u>PHILIP FRIEDEL</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				14. MOTHER'S MAIDEN NAME <u>ROSE ?</u>	
16. SOCIAL SECURITY NO.				17. INFORMANT <u>MRS. LA RUE FRIEDEL, 3223 SPAULDING AVE. #15</u>	
18. <u>436.9 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) <u>Massive Coronary Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF: <u>24 hrs</u>	
19. DATE OF OPERATION <u>2</u> 20A. AUTOPSY? (Yes or No) <u>Yes</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> 19 <u>68</u> to <u>5/2</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>11:54 5/2</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. M. Heller</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>J.M. Heller</u>				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-3-68</u>		24C. NAME of CEMETERY or CREMATORY <u>HEBREW FRIENDSHIP</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>		24E. STATE <u>MARYLAND</u>		24F. ZIP CODE <u>21201</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	



68- 4715

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4715

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Thater, Melva</i>		2. DATE AND HOUR OF DEATH <i>5-3 '68</i>   <i>035A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Franklin Square Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>11/19/18</i>		9. AGE (in years lost birthday) <i>48</i>		10. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>saleslady Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>department store</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore MD</i>	
13. FATHER'S NAME <i>Samuel Earley</i>		14. MOTHER'S MAIDEN NAME <i>Rachael Schaeffer</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>212-34-7940</i>		17. INFORMANT <i>Murrill Thater</i>		ADDRESS <i>18422 Loch Raven Blvd. 21204</i>	
18. <i>250.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury at complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Standstill</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF:			
(C) <i>Diabetes AS ED.</i>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>260X</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4-22</i> 19 <i>68</i> to <i>5-3</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5-3</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Mek Young</i>		23B. DATE SIGNED <i>5-3-68</i>		23C. PHYSICIAN'S NAME (Type) <i>Mek Young</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/7/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Western Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		24E. NAME OF REGISTRAR <i>Robert E. Taylor</i>		24F. FUNERAL DIRECTOR <i>Walters Funeral Home Pratt &amp; Stricker</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 6 1968</i>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	

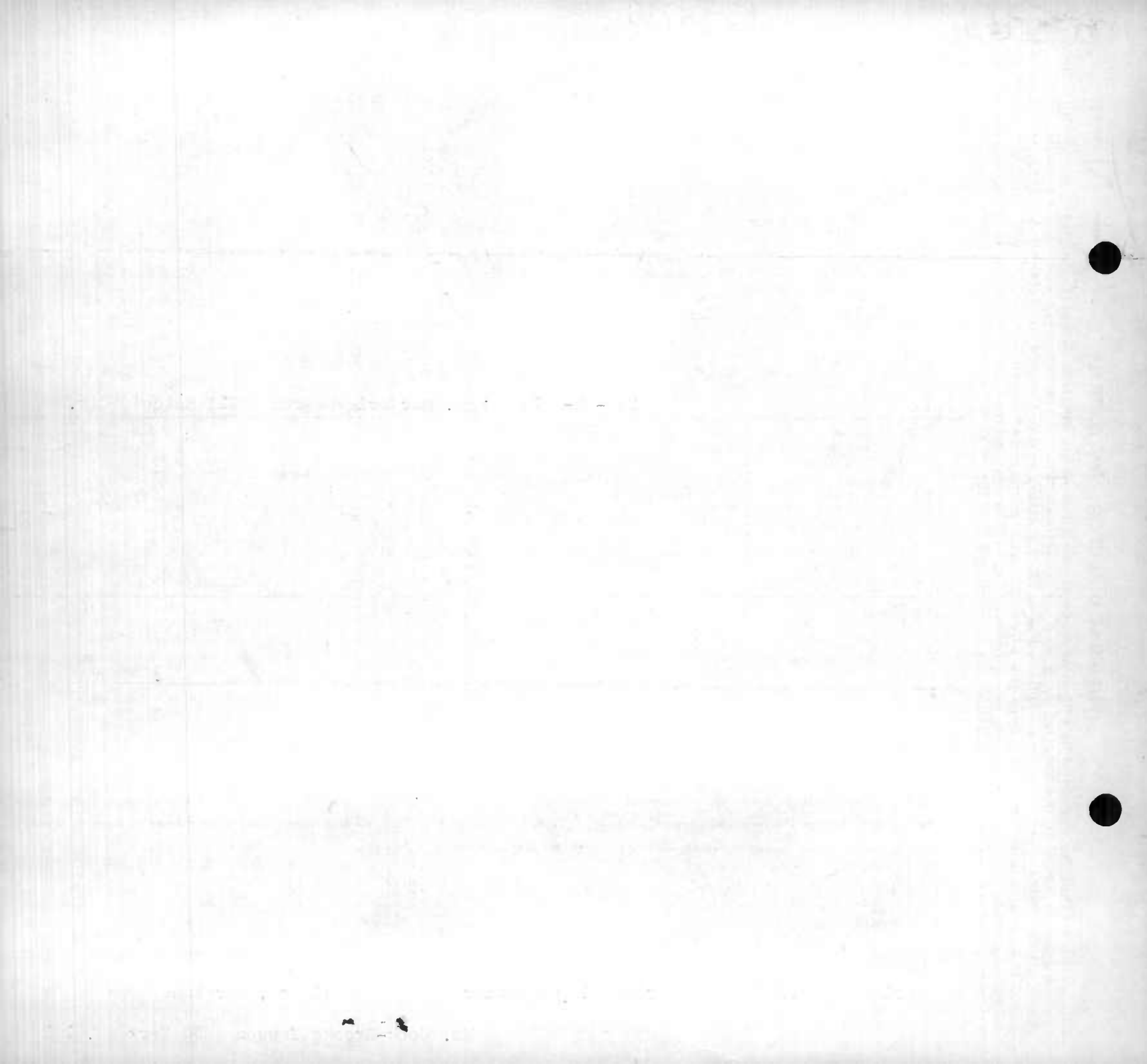




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">68-4716</span>	
1. NAME OF DECEASED (Type or Print) <i>Ethel L. Morse</i>		2. DATE AND HOUR OF DEATH <i>May 1, 1968 11:50 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Maryland</i> B. COUNTY <i>13-07</i>	
		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <i>Roland View Towers</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-5-85</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Robert L. Lloyd</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Ebsor</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-32-3471</i>		17. INFORMANT ADDRESS <i>Mrs. Marjorie LeBrun 10321 Malcolm Cir.</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Heart Failure</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD &amp; Coronary Thrombosis</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic G(7) - undocumented</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>433.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>my</del> (this hospital) attended the deceased from <i>4-22-68</i> 19 to <i>5-1-68</i> 19, that <del>my</del> (we) last saw the deceased alive on <i>5-1-68</i> 19 and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <del>did</del> (did not) view the body after death.					
23A. SIGNATURE <i>Bayan L. Manalo, M.D.</i>		23B. DATE SIGNED <i>5-1-68</i>		23C. PHYSICIAN'S NAME (Type) <i>BAYAN L. MANALO, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/3/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Driod Ridge Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		24E. NAME OF REGISTRAR <i>Robert E. Tashy</i>		24F. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Brooks Towson 1050 York Rd. 21208</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 6 1968</i>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4717 <b>CERTIFICATE OF DEATH</b> X				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4717	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <b>EFFIE LUCILLE TALKINGTON</b>				2. DATE AND HOUR OF DEATH <b>5-4-68</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 CITY HOSPITAL</b>				A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTO.</b>	
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>8142 KAVANAGH RD.</b>							
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-21-1914</b>		9. AGE (In years last birthday) <b>53</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITRESS</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>AUSTRABOND</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-32-3524</b>		17. INFORMANT <b>Th. Woodrow W. Talkington</b>		ADDRESS <b>8142 Kavanagh Rd.</b>	
18. <b>135 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia - (lungs)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:			
138.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1959</b> to <b>2-25-68</b> that (I) (we) last saw the deceased alive on <b>2-25</b> <b>19.68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Laura J. [Signature]</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/6/68</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-8-68</b>		24C. NAME of CEMETERY or CREMATORY <b>MEADOWRIDGE Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>[Signature]</b>		ADDRESS <b>2334 Jefferson St.</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4718

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 4718

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAM NOELLERT, Sr.</b>		2. DATE AND HOUR OF DEATH <b>5-2-68</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>7-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>622 N. KENWOOD AVE.</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>622 N. KENWOOD AVE.</b>							
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-11-1895</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEEL WORKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL IND.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM F. NOELLERT</b>				14. MOTHER'S MAIDEN NAME <b>LOUISE KRAMMER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>21522 4454</b>		17. INFORMANT <b>Mrs. Catherine P. Noellert</b>		ADDRESS <b>8-622 Kenwood Ave.</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCL. C. V. DIS.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROSIS, GENERALIZED</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCL. C. V. DIS.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>	
19. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) <b>ARTERIOSCLEROSIS, GENERALIZED</b> <b>5 YEARS</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/2/64</b> 19 to <b>5/2/68</b> 19, that (I) ( <del>we</del> ) last saw the deceased alive on <b>5/1/68</b> 19 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.							
23A. SIGNATURE <b>Benj. B. Moses, M.D.</b>				23B. DATE SIGNED <b>5/3/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Benj. B. MOSES, M.D.</b>	
23D. ADDRESS <b>448 N. LUZERNE AVE. BALTO. MD</b>				23E. PHYSICIAN'S NAME (Type) <b>Benj. B. MOSES, M.D.</b>		23F. ADDRESS <b>448 N. LUZERNE AVE. BALTO. MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-6-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Garth Miller - 2334 Jefferson St.</b>		ADDRESS <b>2334 Jefferson St.</b>	

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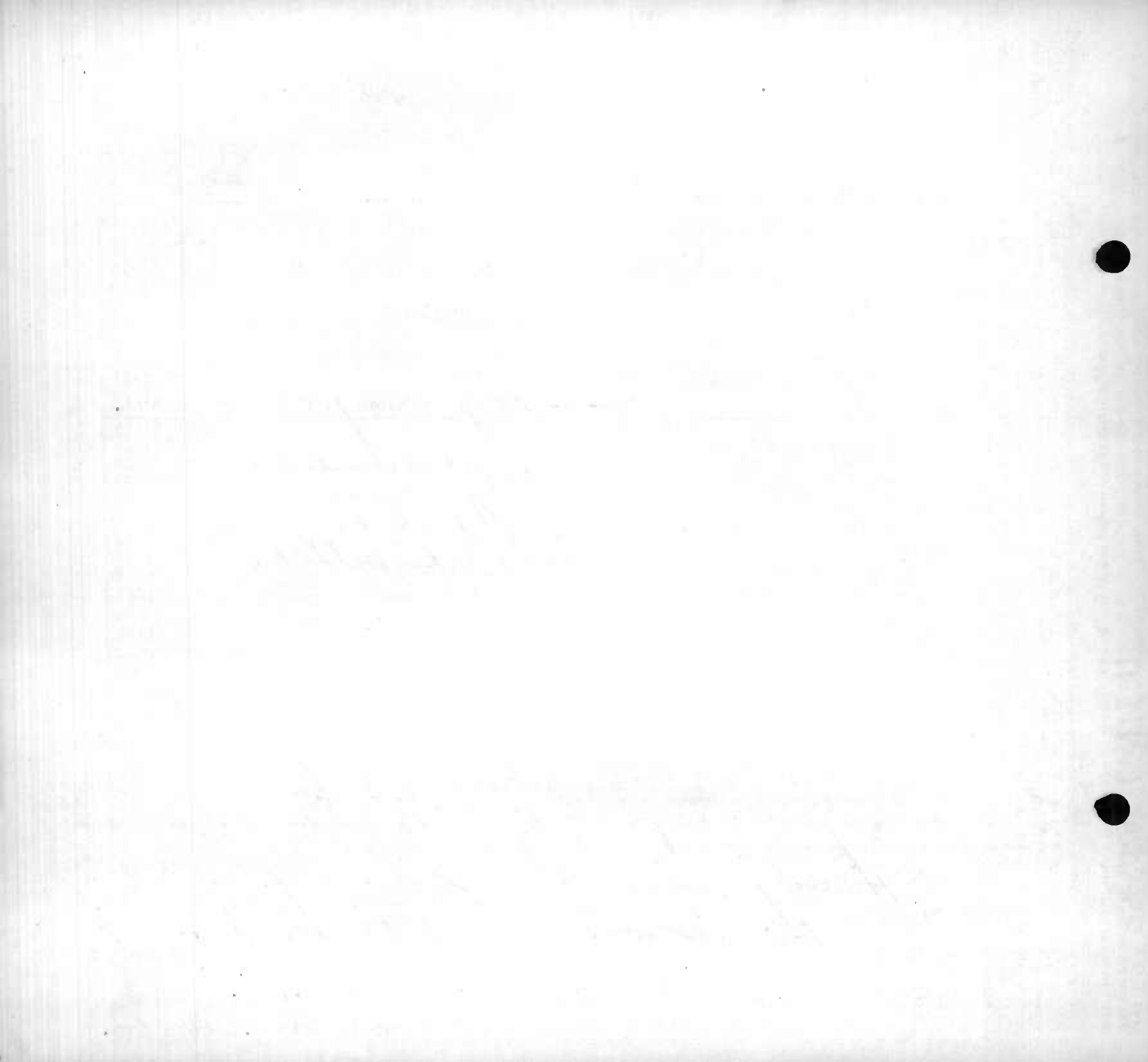
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 4719				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68- 4719	
1. NAME OF DECEASED (Type or Print) <b>Lillian B. Green</b>				2. DATE AND HOUR OF DEATH <b>April 30, 1968</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>306 Parrish Street</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>306 Parrish Street</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>4/30/17</b>	9. AGE (In years last birthday) <b>51</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>215-22-8347</b>		17. INFORMANT ADDRESS <b>Annie Epps / 3714 Cottage Ave.</b>					
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Hypertensive cardiovascular disease</b> DUE TO (B) <b>Ascaris</b> DUE TO (C) <b>Diab. mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
19. <b>260X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-30-68</b> to <b>4-30-68</b> and that (I) (we) last saw the deceased alive on <b>4-30-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>HIROSHI NAKAZAWA</b> M.D.				23B. DATE SIGNED <b>5-3-68</b>		23C. ADDRESS <b>521 W. Lexington St #1</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Phub E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm C March 928 E. North Ave.</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>JOSEPH J. STANLEY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 838 S. Bond Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 1, 1968 10:50 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>OCT 1 1896</b>		10. AGE (In years last birthday) <b>71</b>	
11. BIRTHPLACE (State or foreign country) <b>SAN FRANCISCO CALIF</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BOXER</b>		15. MOTHER'S MAIDEN NAME <b>UNK</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WORLD WAR I</b>		17. SOCIAL SECURITY NO. <b>005-26-5074</b>	
18. INFORMANT <b>LEONA MARIE GIRDANO</b>		ADDRESS <b>1603 SHAKESPEARE ST</b>	
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20. DATE OF OPERATION <b>2</b>		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>222.1 II</b>	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		DATE SIGNED <b>May 2, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>MAY 7 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>BALTO NATIONAL CFM</b>		24D. LOCATION (City, town, or county) (State) <b>FREDERICK RD BALTO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Schuyler</b>	
25C. FUNERAL DIRECTOR <b>THE DIPPEL BROS INC</b>		ADDRESS <b>1800 E LOMBARD ST</b>	

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## FUNERAL DIRECTOR: IMPORTANT

BY DR. KORNBLUM OF THE MEDICAL EXAMINER'S OFFICE  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-4721	
W-630 66-13665-68-4721 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
THERESA PERCELL WARD			5/4/68 1:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
33 Johns Hopkins Hospital Baltimore, Md 21205			2224 E. Biddle St. Balt., Md.		
5. SEX F			6. RACE N		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 7/2/66		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (In years lost birthday) 1		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Md.		
13. FATHER'S NAME Kenneth			12. CITIZEN OF WHAT COUNTRY? U.S.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME Fannie Walton		
16. SOCIAL SECURITY NO.			17. INFORMANT Mother		
18. 428X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			Arteriosclerosis		
ANTECEDENT CAUSES			Arrival.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Congestive Failure + shock?		
			(C) ?? Myocarditis.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 5/3 10:22 PM 19 68 to 5/4 1:45 AM 19 68, that (we) last saw the deceased alive on 5/4 19 68 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE H. Abraham MD. DEGREE				23B. DATE SIGNED 5/4/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 5/7/68	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem				24D. LOCATION (City, town, or county) (State) Balt. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1968		25B. NAME OF REGISTRAR R. B. E. Farley		25C. FUNERAL DIRECTOR ADDRESS WM MARCH 928 E North Arc	

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-635		68-4722		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68 4722	
1. NAME OF DECEASED (Type or Print) <b>Harding, Baby Boy - Ruth</b>				2. DATE AND HOUR OF DEATH <b>8:30 AM 4/30/68</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived, if in residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1049 North Durham Street 21205</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-29-1968</b>	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <b>Ruth Harding</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records: BCH-4940 Eastern Avenue 21224</b>			
18. <b>776.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>773.3-11</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Prematurity (820 gms.)</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Anoxia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Hyaline Membrane Pulmonary insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Hyaline Membrane</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/29 1968</b> to <b>4/30 1968</b> , that (I) (we) last saw the deceased alive on <b>4/30 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Frank Bouya</b>				23B. DATE SIGNED <b>4/30/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Frank Bouya</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>5-1-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore City Hospitals</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21224</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>HOSPITAL DISPOSAL</b>			



10/20/94 11:00 AM - 12:00 PM

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11/20/94 11:00 AM - 12:00 PM

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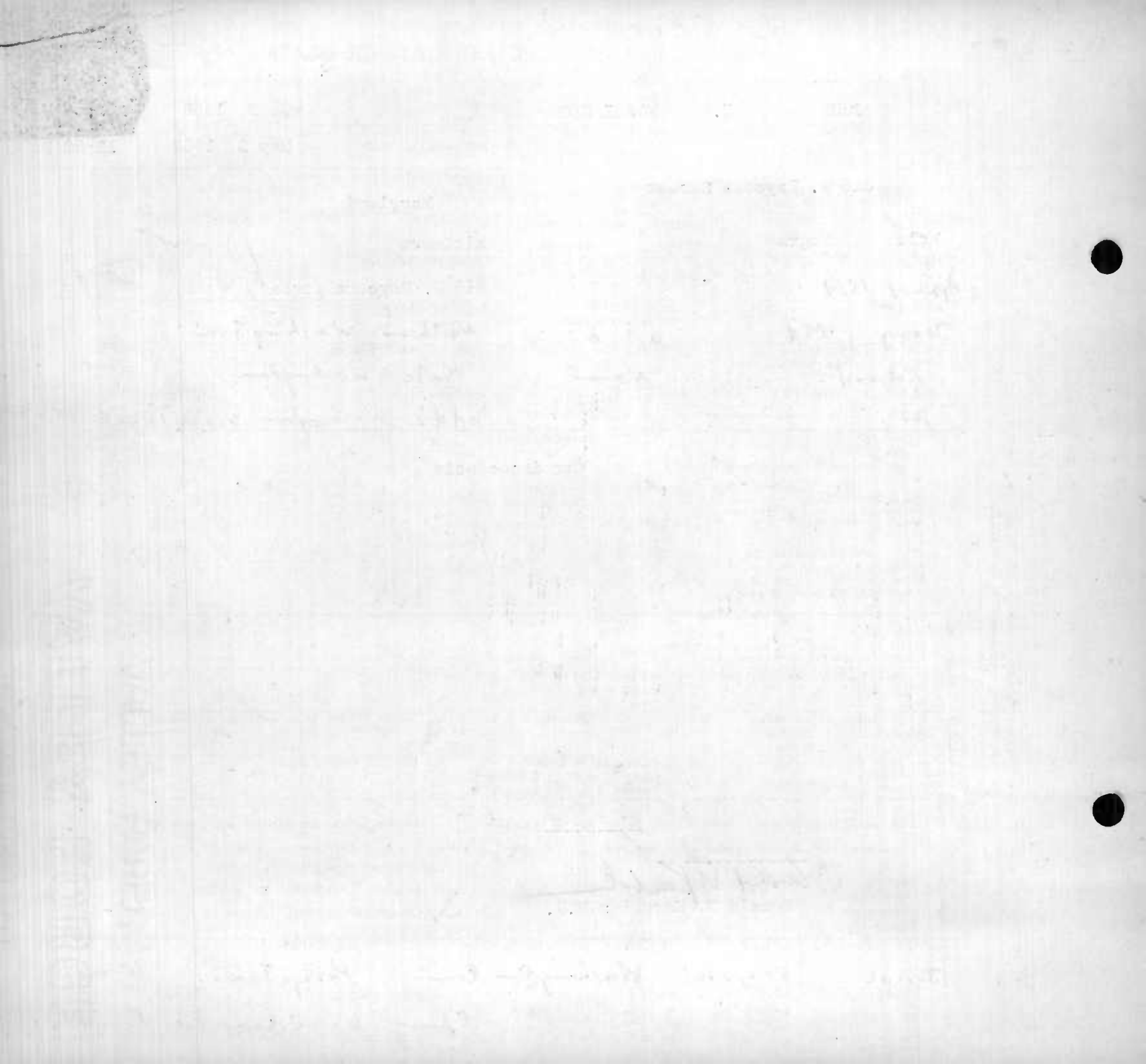
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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

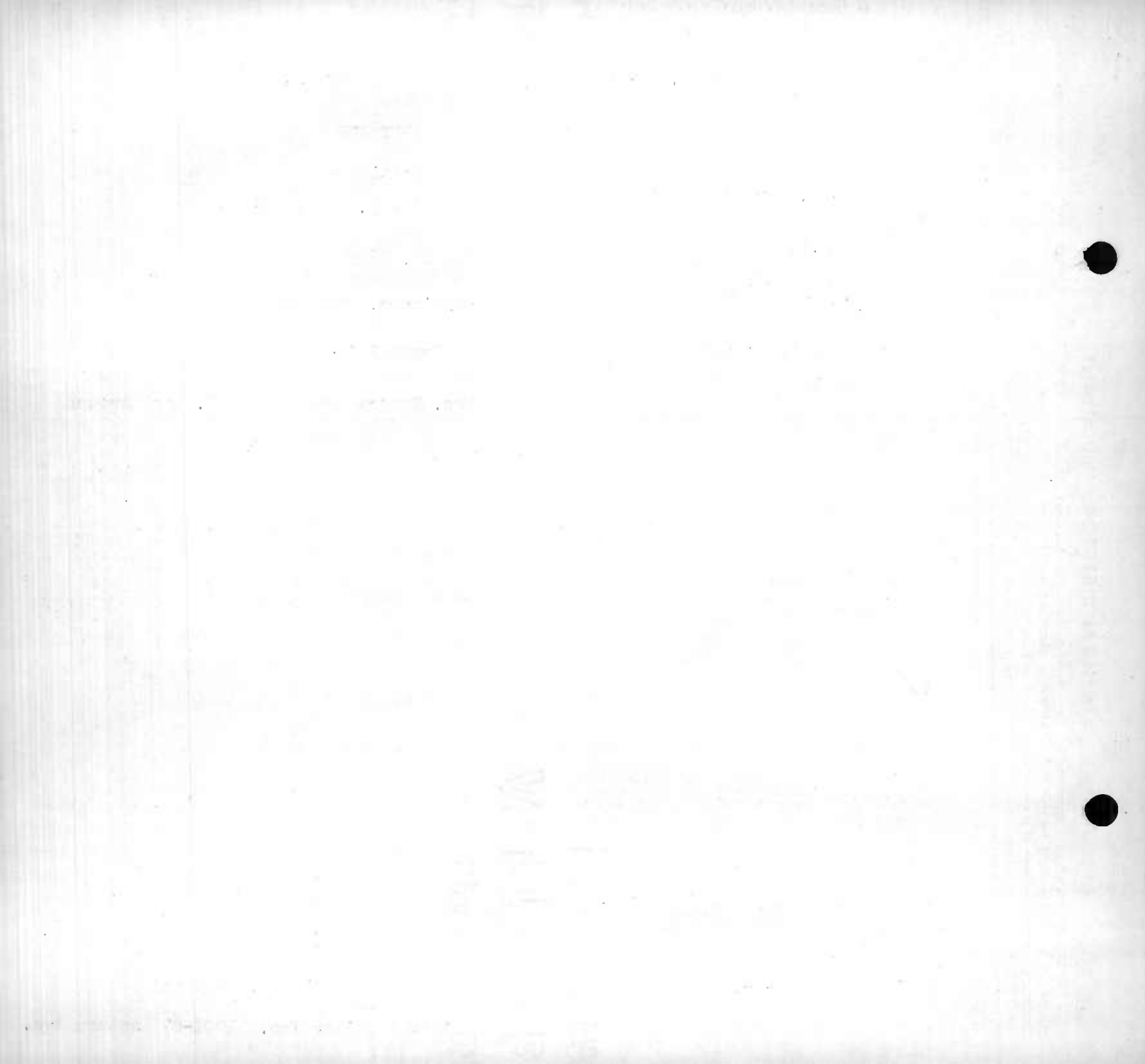
1. NAME OF DECEASED (Type or Print) <b>JOHN I. WASHINGTON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 3, 1968</b> <b>12:50 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>816 W. Fayette Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 3, 1968</b> <b>12:50 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>April 18, 1889</b>		10. AGE (In years lost birthday) <b>79</b>	
11. BIRTHPLACE (State or foreign country) <b>Jessup, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME <b>Kate Washington</b>		18. INFORMANT <b>addie Washington 816 W. Fayette St.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>199.0 Carcinomatosis</b>		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>199.2 II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-6, 1968</b>	
24C. NAME of CEMETERY or CREMATORY <b>Washington Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>George Town Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, MA</b>	
25C. FUNERAL DIRECTOR <b>Cherry D. Williams</b>		ADDRESS <b>1000 Brantley Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

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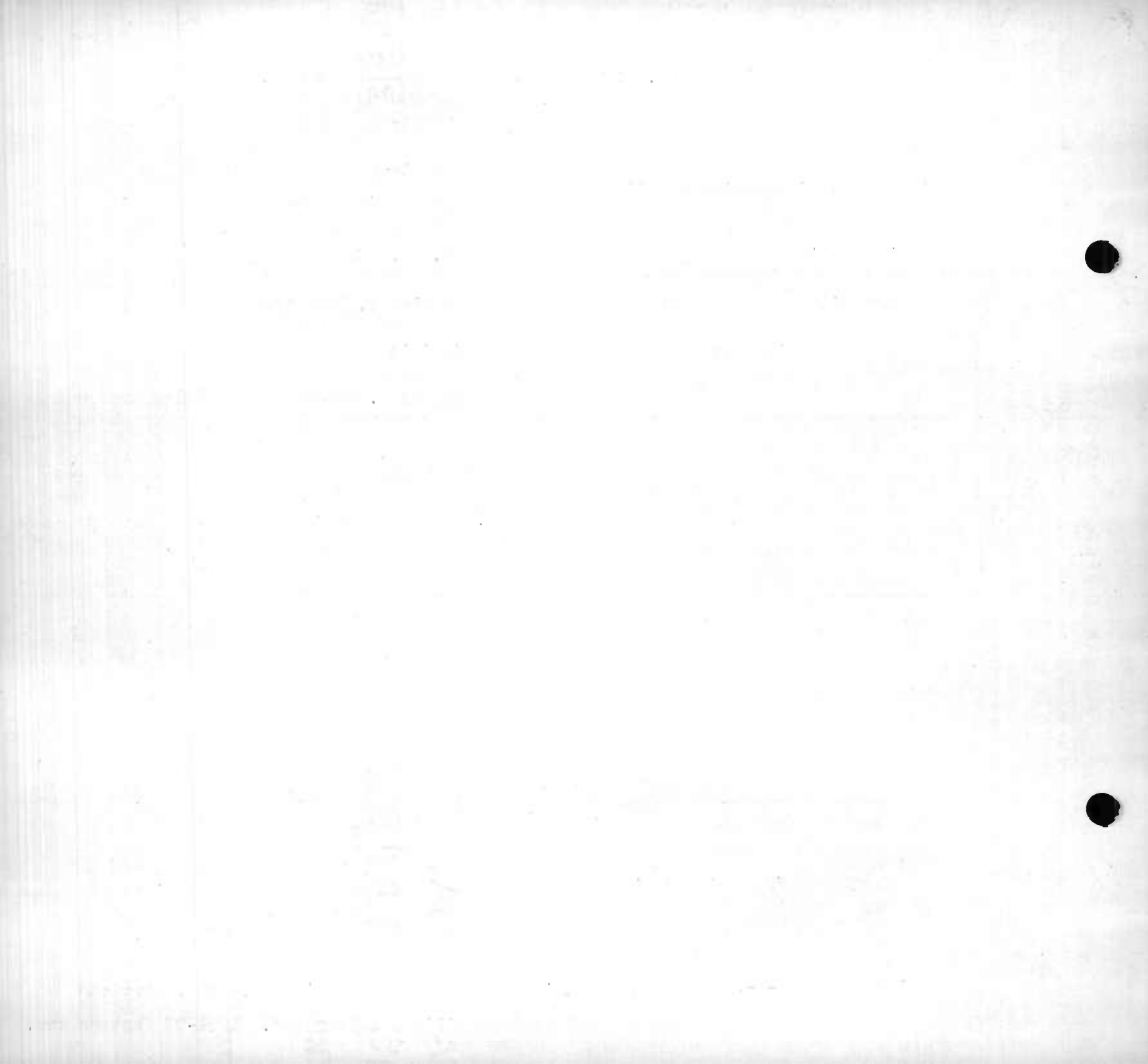
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4724	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FRANCES L. MICHEL		May 4, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  124 S. Curley Street			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 124 S. Curley Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1895	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME John Michel			14. MOTHER'S MAIDEN NAME Susan Feihe		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Teresa Adams 336 S. East Avenue	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Atherosclerotic C. V. Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized Atherosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown 3 years	
MEDICAL CERTIFICATION					
260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/8 1965 to 5/4/68 1968, that (I) (we) last saw the deceased alive on 5/3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Henry J. Houska				23B. DATE SIGNED 5/6/68	
23C. PHYSICIAN'S NAME (Type) HENRY J. HOUSKA				23D. ADDRESS 333 S. EAST AVE BALTO. MD	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 5-8-1968		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1968		25B. NAME OF REGISTRAR Robert E. Farley, MD		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4725	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)	
				<b>LILLIAN C. KUCZAK</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <b>May 3, 1968</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1-01</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3105 Foster Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1908</b>	9. AGE (In years lost birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Felix Kalendek</b>			14. MOTHER'S MAIDEN NAME <b>Cecilia</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Stephen P. Kuczak</b> ADDRESS <b>3836 Elmley Avenue</b>	
18. <b>250.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Diabetic Coma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>Diabetes mellitus</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>MORE 10 years</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>260X II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>October 4-18</b> 19 <b>68</b> to <b>May 3</b> , 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4-18</b> 19 <b>68</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <b>Melito M. Torres, M.D.</b>				23B. DATE SIGNED <b>5-6-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MELITO M. TORRES, M.D.</b>				23D. ADDRESS <b>441 S. ELLWOOD AVENUE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-7-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</b>			

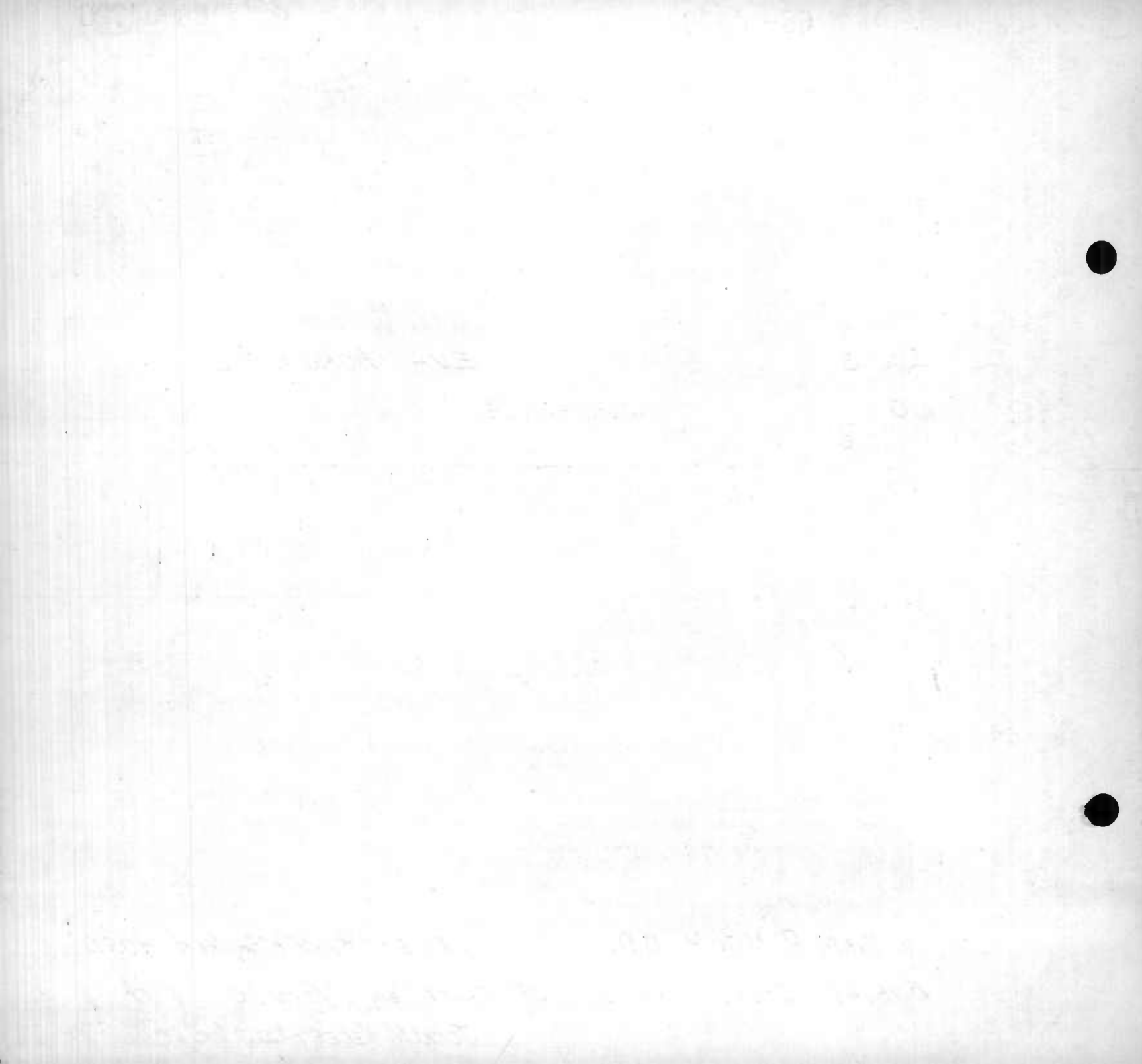




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4726	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Rose Chesser</u>		2. DATE AND HOUR OF DEATH <u>2 May 68</u>   <u>10<sup>45</sup></u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u> <u>38</u>			C. CITY OR TOWN <u>Dundalk</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Female</u>			6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>4/27/02</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		9. AGE (In years lost birthday) <u>66</u>	
13. FATHER'S NAME <u>LOUIS HANDWERGER</u>			14. MOTHER'S MAIDEN NAME <u>EVA HOROWITZ</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>N/O</u>			16. SOCIAL SECURITY NO. <u>216-09-2866A</u>		17. INFORMANT <u>Medical Record</u>
18. <u>571.8</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Chronic Renal Disease</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Nutritional Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>581.0</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>2 May 68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>DIAGNOSTIC Exploratory LAPAROTOMY</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>7 Feb</u> 19 <u>68</u> to <u>2 MAY</u> 19 <u>68</u> , that (1) (we) lost the deceased alive on <u>2 MAY</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William E. Mock M.D.</u>				23B. DATE SIGNED <u>2 May 68</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM E. MOCK M.D.</u>				23D. ADDRESS <u>UNIVERSITY OF MARYLAND HOSP</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-6-68</u>		24C. NAME of CEMETERY or CREMATORY <u>GARDENS OF FAITH Cem</u>	
24D. LOCATION <u>BALTO MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Tarkenton</u>		25C. FUNERAL DIRECTOR <u>John M. Weber &amp; Sons Inc</u>			
25D. ADDRESS <u>401 S. CHESTER ST.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4727</b>
H-232		68-4727 <b>CERTIFICATE OF DEATH</b>		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Hawkins, Nathaniel</b>		2. DATE AND HOUR OF DEATH <b>5/2/68 10:00 A.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Univ. of Maryland Hosp.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M</b>		6. RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>12/3/07</b>		9. AGE (In years lost birthday) <b>60</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipyard worker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>USA (Balto.)</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry Hawkins</b>		14. MOTHER'S MAIDEN NAME <b>Anna Smith</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>213-61-8540</b>		17. INFORMANT <b>Hosp records</b>
ADDRESS <b>Green + Redwood Balto</b>		18. <b>398X I</b> CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) <b>RHEUMATIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 YEARS</b>		
19A. DATE OF OPERATION <b>2 None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>3/28 1968</b> to <b>5/2 1968</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>5/2 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (We) (did) (did not) view the body after death.		
23A. SIGNATURE <b>A.L. Markowitz, MD</b>		23B. DATE SIGNED <b>5/2/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Sheldon L. Markowitz</b>
23D. ADDRESS <b>Univ. Hosp. Green + Redwood Sts. Balto. Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>5-7-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Nelson F. H.</b>
ADDRESS <b>1348 N. Calhoun St.</b>				

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 4728
I-22C 68- 4728		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Rev. John Benjamin St. Felix Isaacs		May 2, 1968 11:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  2702 Elsinor Ave			A. STATE Maryland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			C. CITY OR TOWN Baltimore		
			E. STREET AND NUMBER 2702 Elsinor Ave		
5. SEX Male	6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1887	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10B. KIND OF BUSINESS OR INDUSTRY Clergy		11. BIRTHPLACE (State or foreign country) Georgetown, British Guiana	
13. FATHER'S NAME Simon Isaacs		14. MOTHER'S MAIDEN NAME Phyllis ?		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 550-26-6599		17. INFORMANT Mrs. Esther B. Isaacs	
				ADDRESS 2702 Elsinor Ave	
18. 23-0-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Due to, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident 5-2-68 (B) Cardio-Vascular Renal Disease 6 mo. (C) Diabetes Mellitus 2 yrs		
19. 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-2-68 19 to 5-2-1968 that (I) (we) last saw the deceased alive on 5-2-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. Bradshaw Higgins				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) I. Bradshaw Higgins		23D. ADDRESS 2243 Madison Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/68		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
				24D. LOCATION (City, town, or county) (State) Arbutus Balto Co., Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1968		25B. NAME OF REGISTRAR Robert E. Higgins		25C. FUNERAL DIRECTOR Herbert E. Nutter	
				ADDRESS 3035 W. North Ave	

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4729

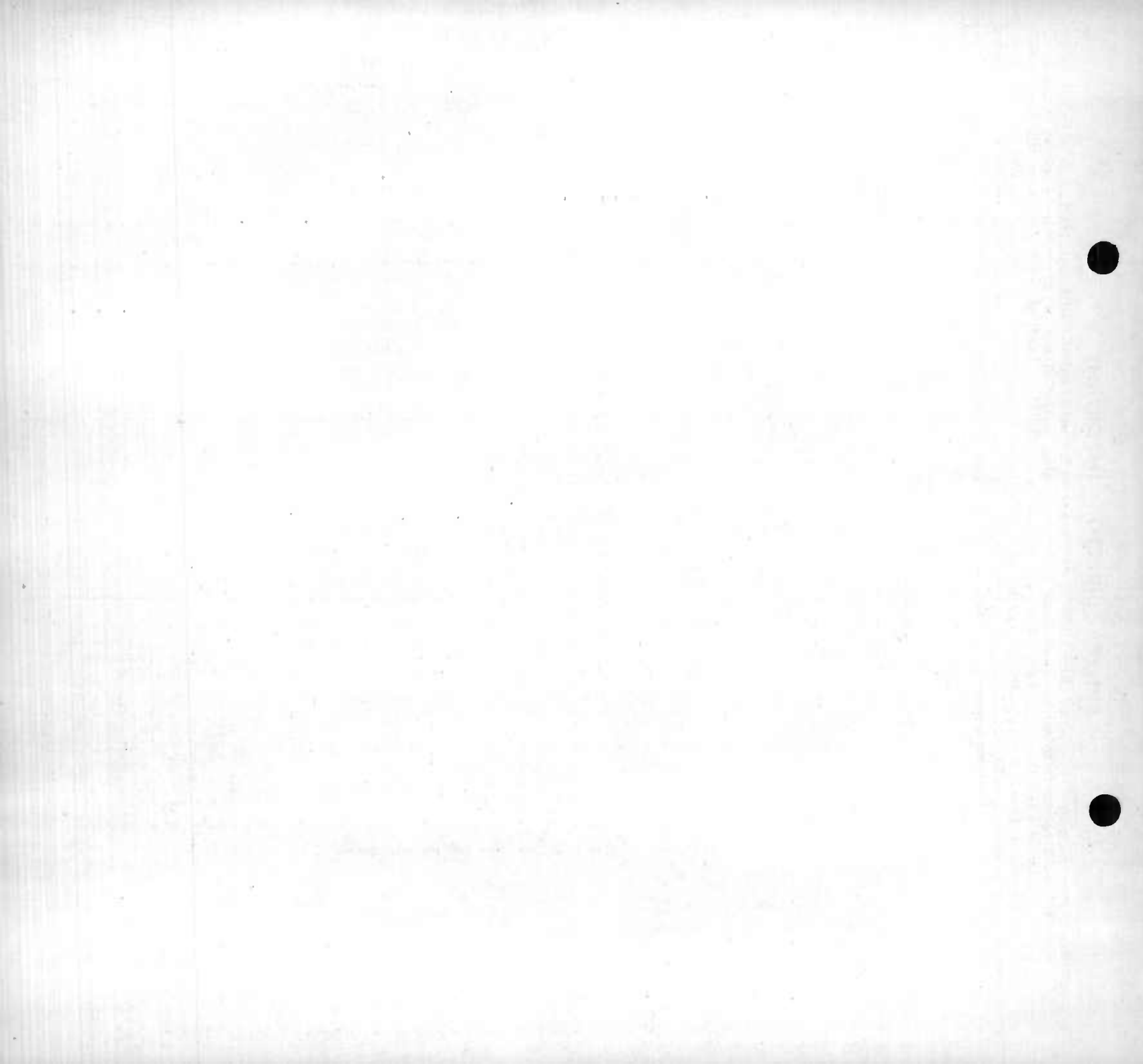
**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO.

68- 4729

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Bertie DeNeal		5-2-68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  2426 Wilgray Ct. Balto., Md.				A. STATE Md.	
				B. COUNTY	
C. CITY OR TOWN Balto.				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 725 George St. Apt. 10P	
5. SEX Female	6. RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-6-00	9. AGE (In years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Virginia	
13. FATHER'S NAME Timothy Lee				14. MOTHER'S MAIDEN NAME Fannie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214168655		17. INFORMANT Gladys DeNeal	
				ADDRESS 2426 Wilgray Ct.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: - Cerebral Vascular Thrombosis of Right Middle Cerebral Artery (B) DUE TO, OR AS A CONSEQUENCE OF: - Pseudosclerotic Cerebral Vascular Disease (C) ...	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 25 Apr 1968 to 1 May 1968, that (I) (we) last saw the deceased alive on 1 May 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED 3 May 68	
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 5-6-68	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D. BY HEALTH DEPT. MAY 6 1968				25B. NAME OF REGISTRAR [Signature]	
				25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.	



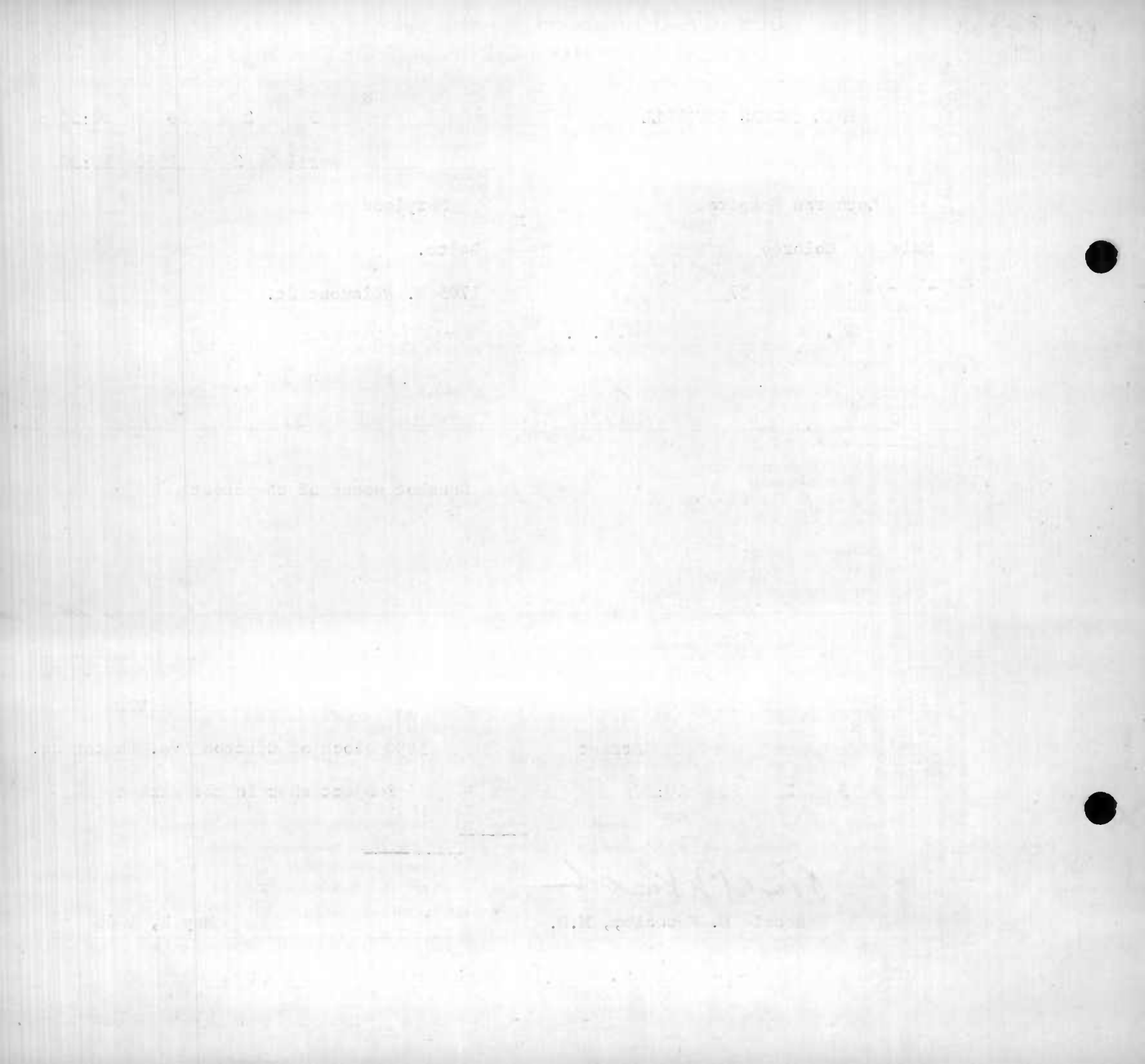


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>PAUL THOMAS HOPEWELL</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 5 2 68 10:50 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>Max April 2 1968 10:50 p.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>Colored</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-06</b>	
9. DATE OF BIRTH <b>7-29-30</b>		10. AGE (In years last birthday) <b>37</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>217269910</b>	
18. INFORMANT <b>Cecelia Hopewell</b>		ADDRESS <b>3916 Coldsprings L.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>E965X</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Gunshot wound of the chest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID INJURY OCCUR? <b>3800 block of Clifton Ave. in the st.</b>		22F. HOW DID INJURY OCCUR? <b>Subject shot in the street</b>	
22D. TIME OF INJURY (APPROX.) 5 2 68 10:30p		22E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>May 3, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-7-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Nelson, Funeral Home</b>		ADDRESS <b>1348 Calhoun St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4731

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 4731

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES WALLACE</b>		2. DATE AND HOUR OF DEATH <b>5/2/68</b> <b>5:15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>16-05</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>488 Md. General Hosp</b>				C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>614 N PULASKI</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-26-10</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GARDENER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>Henry Wallace</b>			14. MOTHER'S MAIDEN NAME <b>ANNA WHITE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>P</b>		17. INFORMANT ADDRESS <b>PT'S CHART CATHERINE Jackson - Daug.</b>	
18. <b>412.4 I</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive Pulmonary embolism</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>					
18. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-16</b> 19 <b>68</b> to <b>5-2</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5-2</b> 19 <b>68</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>F. S. Zorick MD</b>				23B. DATE SIGNED <b>5-2-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>F. S. Zorick MD</b>				23D. ADDRESS <b>MD Gen'l Hosp Balto</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-6-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Pr.</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Kelson F. H. 1348 N. Calhoun St.</b>			



W-425 68-4732 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. 68-4732

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROBERT EDWARD WILSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 4, 1968</b> 7:04 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1923 Herbert Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 4, 1968 7:04 A. M.</b>		5. USUAL RESIDENCE (Where deceased lived: If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>11-9-1939</b>		10. AGE (In years last birthday) <b>28</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER <b>1923 Herbert Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Wilson</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Lillian Lewis</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Joseph Wilson 1923 Herbert St. 21217</b>	
19. <b>282.5</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Sickle Cell Anemia</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
292.6 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Epilepsy</b>					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>5-4-68</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-8-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <b>1735 Harford Ave. 21213 Marshall W. Jones, Jr.</b>			

WILLIAM B. COCHRAN



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4733	
<div style="display: flex; justify-content: space-between;"> <span><b>F-462</b></span> <span><b>68- 4733</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Ida Virginia Flowers		May 5, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  90 House In the Pines, Belvedere			A. STATE Maryland		
			B. COUNTY Baltimore		
5. SEX F			6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/7/1882
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 86
Teacher - Principal - Dept. of Education			Maryland		11. BIRTHPLACE (State or foreign country)
					12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John P. Flowers			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-44-0696		17. INFORMANT Mrs. Mary Kaiser
					ADDRESS (Same)
18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Bronch. pneumonia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Chloroform given</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 day?		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1961 to May 5, 1968, that (I) last saw the deceased alive on 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. G. Helfrich</i>				23B. DATE SIGNED May 6, 1968	
23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich				23D. ADDRESS 5006 Roland Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5/8/68		Loudon Park	
24D. LOCATION		24E. LOCATION (City, town, or county) (State)			
Baltimore,		Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 6 1968		Robert E. Fairburn		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

Robert. Brown. 1841  
Cincinnati. Ohio.

1841  
x  
C. B. Brown

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 4734
J-525 68- 4734		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JENSEN, MRS. KATHLEEN H.		5. 4. 68 1-30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
CHURCH HOME AND HOSPITAL			MARYLAND Baltimore 53-00		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			STEVENSON,		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER COTTAGE RD. STEVENSON, MARYLAND 21153		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	W W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9-13-90	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House wife		OWN HOME		CANADA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
R.D. WILLIAM HOLLADAY			ELIZABETH L. MARKS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		220-443439		C. THOMAS JENSEN, JR. CRADOCK LANE GARRISON, MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
430.0 I					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE		
ANTECEDENT CAUSES			Central Respiratory failure		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			Subarachnoid Hemorrhage		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Hypertension		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
330X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5-3 1968 to 5-4 1968, that (I) (we) last saw the deceased alive on 5-4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Veneracion Jr.			May 4, 1968		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
VENERACION JR.			CHURCH HOME AND HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/7/68		St. Thomas'	
				Garrison Forest, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 6 1968		Robert E. Jenkins		H. W. Jenkins & Sons Co. 4905 York Rd Balto. 12, Md.	

CHURCH LEASE AND MAP OF

STEVENS

STEVENS

STEVENS, BOSTON 2112

4-15-90

CHAD

ELIZABETH L. WARD

THOMAS JENSEN

CHURCH LEASE

STEVENS

STEVENS

11 Dec 11

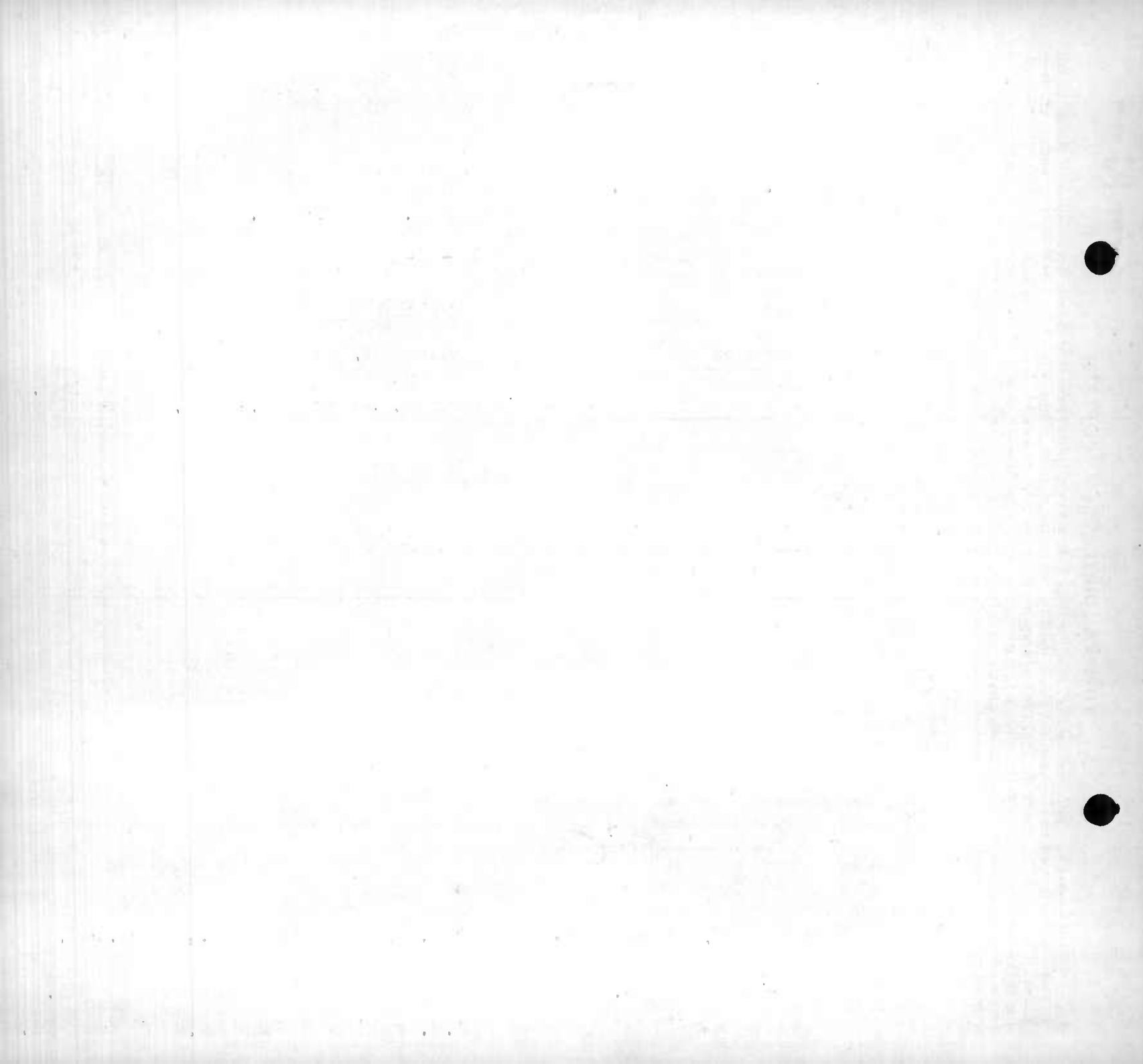
11 Dec 11

11 Dec 11

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4735</b>	
<div style="font-size: 2em; font-weight: bold;">5-520 68-4735</div>				<div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div>	
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>Frances Cannan Semmes</b>				<b>2. DATE AND HOUR OF DEATH</b> <b>May 3, 1968</b> <span style="float: right;">10:45 AM</span>	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>222 W. Lanvale St.</b>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
<b>5. SEX</b> <b>F</b> <b>6. RACE</b> <b>W</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> <b>11-12-1883</b> <b>9. AGE</b> (In years lost birthday) <b>84</b> <b>10. A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Never Employed</b> <b>10B. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>				<b>13. FATHER'S NAME</b> <b>John Edward Semmes</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Frances C. Hayward</b>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>220-44-1202</b>				<b>17. INFORMANT</b> <b>John E. Semmes Jr.</b> <b>ADDRESS</b> <b>100 W. University Pkwy.</b>	
<b>18. CAUSE OF DEATH</b> <b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b>	
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>19A. DATE OF OPERATION</b> <b>4-9-68</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>Myocardial Infarction</b> <b>20A. AUTOPSY?</b> (Yes or No) <b>No</b> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>				<b>3 yrs</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/> <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)				<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 12/20/56 to 5/3/68 19</b> <b>that (I) (we) last saw the deceased alive on 5/3/68 19</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>Francis W. Gluck</i> <b>DEGREE</b> <b>MD</b>				<b>23B. DATE SIGNED</b> <b>5/4/68</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Francis W. Gluck</b>				<b>23D. ADDRESS</b> <b>100 W. University Pkwy., Balto., Md.</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>5-7-68</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>St. Thomas</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Garrison Forest Md.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 6 1968</b> <b>25B. NAME OF REGISTRAR</b> <b>R. E. Jenkins</b> <b>25C. FUNERAL DIRECTOR</b> <b>H.W. Jenkins &amp; Sons Co.</b> <b>ADDRESS</b> <b>4905 York Rd.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">68- 4736</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">K-100</span> <span style="font-size: 1.5em;">68- 4736</span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
IDA M. KOIV			May 4, 1968. <span style="float: right;">8<sup>00</sup> P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <div style="text-align: center; font-size: 1.2em;">6714 Danville Avenue</div>			A. STATE <div style="text-align: center; font-size: 1.2em;">Md.</div>		
			B. COUNTY		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			6714 Danville Avenue		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. UNDER 1 Yr. Months Days
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 2, 1887.	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Estonia		Latvia
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Karl Kiidron			Sophie Troon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			219-30-0706		Mr. Friedrich Koiv
					(Sa me)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3 months
			Metastatic carcinoma		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		6 months
			Carcinoma of the thyroid		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Old age		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
194X					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">5-15-1955</span> to <span style="font-size: 1.2em;">5-4-1968</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5-4-1968</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Paul H. Anniko				5-6-1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
PAUL H. ANNICO				3800 ERDMAN AVE BALTIMORE, MD. 21213	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	5/8/68.	Oaklawn Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 8 1968		Robert E. Jackson		Leonard J. Ruck, Inc. Ba lto. Md. 21214	



Old age

Commission of the States

Metropolitan Museum

PAUL H. ANNEKO

PAUL H. ANNEKO

BALTIMORE, MD. 21218  
4300 BRIDMAN AVE

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2-4-68

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BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 68- 4737	
1. NAME OF DECEASED (Type or Print) <b>Henri Raymond J Clarinval</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> <b>April 29, 1968</b>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>227 S. Broadway - Room 24</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 30, 1968 10:25 A.</b>		M.	
6. SEX <b>male</b>		7. RACE <b>white</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH <b>March 24, 1913</b>		10. AGE (In years last birthday) <b>55</b>		11. BIRTHPLACE (State or foreign country) <b>California</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Marcel Clarinval</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>	
15. MOTHER'S MAIDEN NAME <b>Lucille Hughes</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mary Reilly</b>		19. ADDRESS <b>1006 Woodson Rd</b>		20. CAUSE OF DEATH	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>412.4 I</b>		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>422.1 II</b>	
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) <b>No</b>	
27. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
30. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/30/68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/7/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc</b>		25D. ADDRESS <b>Baltimore, Maryland</b>			

Central & Eastern Europe

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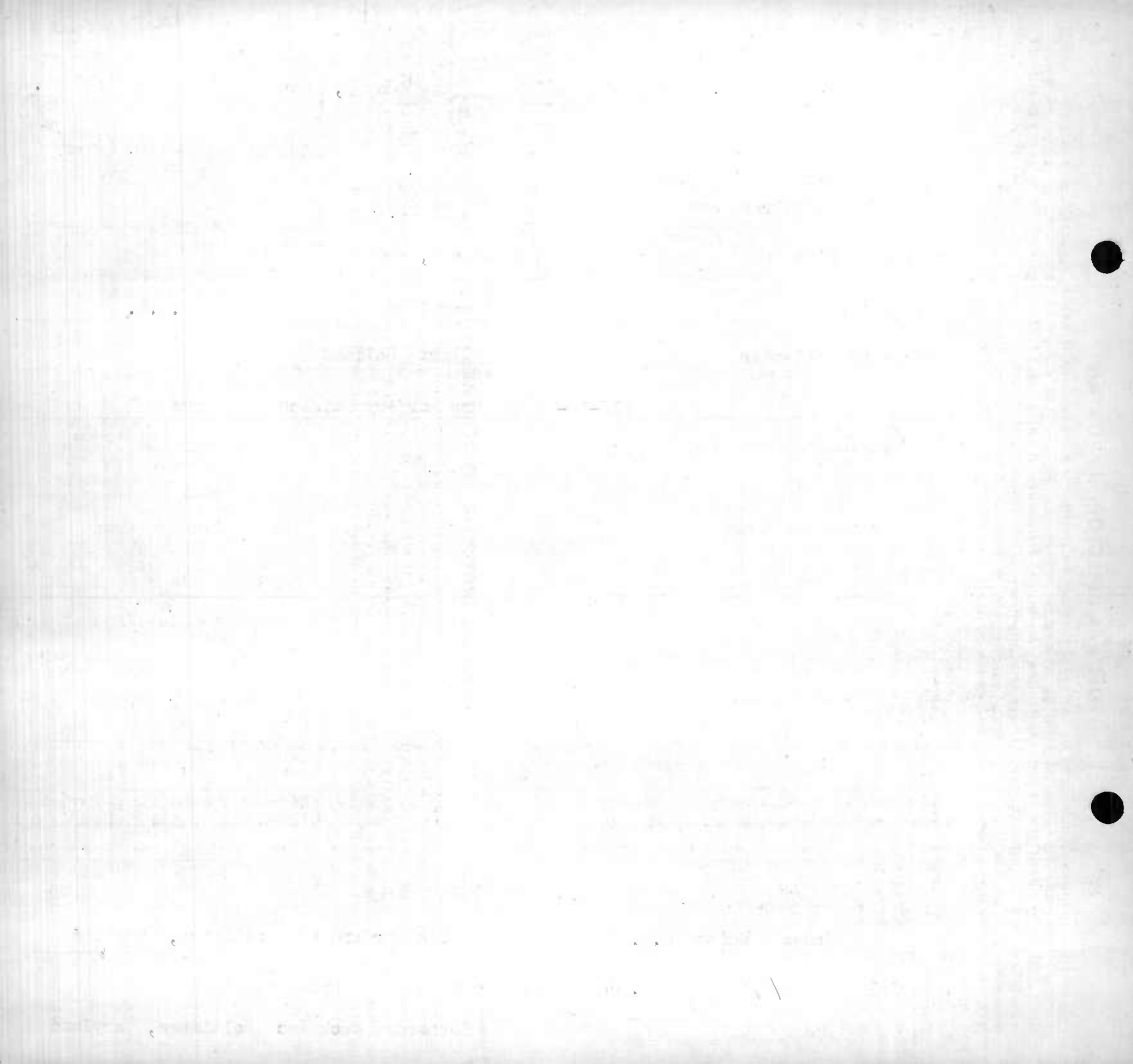
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1990 - 1991

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

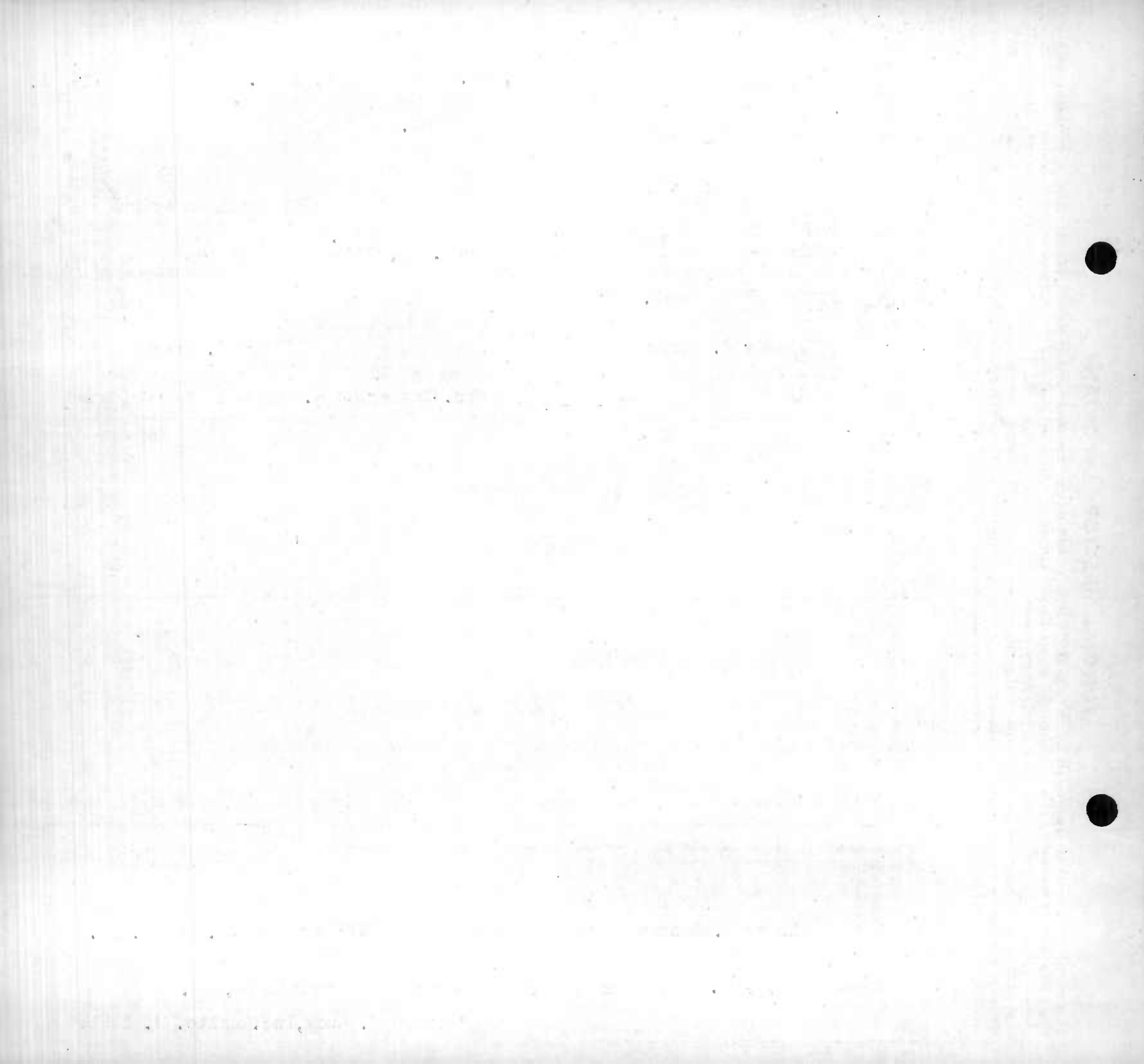
C-560		68- 4738		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68- 4738	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
		Arabella A. Connor				May 3, 1968 6:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
90 Long Green Nursing Home		Maryland				C. CITY OR TOWN D. INSIDE CITY LIMITS			
115 East Melrose Ave		Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER		5224 Harford Rd							
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	June 3, 1900	67	Housewife	Maryland	U.S.A.	Nicholas Allender	Clara Holland
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		215-18-5741A		Mrs Marjory Maisack		Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				Massive Carcinoma of Liver			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:							
156.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from August 1967 to May 3 1968, that (I) (we) last saw the deceased alive on May 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
James E White M.D.						May 3, 1968			
23C. PHYSICIAN'S NAME (Type)		DEGREE		23D. ADDRESS					
James E White M.D.		DEGREE		5214 Harford Rd Baltimore, Maryland					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		5/6/68		St. Johns Long Green		Hydes Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAY 6 1968		Robert E. Farber, M.D.		Leonard J. Ruck Inc		Baltimore, Maryland			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 4739</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>R-248</b></span> <span><b>68- 4739</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>William Edward Russell, Sr.</b>		<b>May 2, 1968. 9:15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>3207 Hamilton Avenue</b>			A. STATE <b>Md.</b>		
			B. COUNTY		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3207 Hamilton Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1911</b> <b>Sept. 13, 1911</b>		9. AGE (In years most birthday) <b>53</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Louis J. Russell</b>		
14. MOTHER'S MAIDEN NAME <b>Ellen T. Brooks</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>245-05-6730</b>			17. INFORMANT <b>Mrs. Katherine R. Russell</b>		
ADDRESS <b>(Same)</b>			18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary Artery Disease</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 Minutes</b>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>5</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1960</b> to <b>Now</b> 19 <b>67</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>Jan. 1968</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Thomas J. Brennan</b>				23B. DATE SIGNED <b>2 May 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>Thomas J. Brennan MD</b>				23D. ADDRESS <b>5217 Harford Rd. Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/68.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	





# FUNERAL DIRECTOR: IMPORTANT

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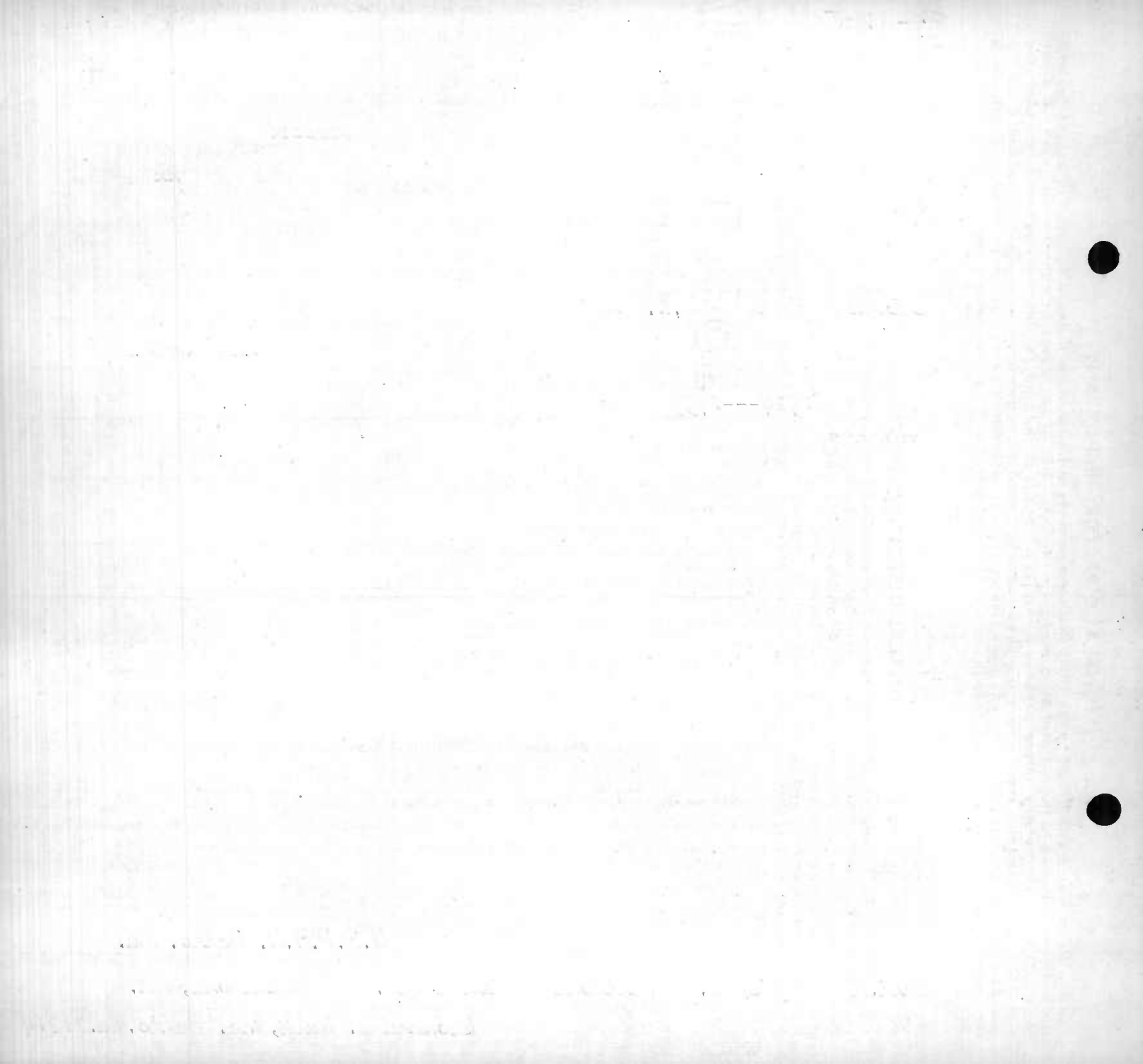
W-325 68-4740		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4740	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>DAVID COLEMAN WATSON</b>			2. DATE AND HOUR OF DEATH <b>May 2, 1968. 4:00 P M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>2904 White Avenue</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2904 White Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1905</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Episcopal Clergyman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Church Rector</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Adam Mott Watson</b>		
14. MOTHER'S MAIDEN NAME <b>Laura Siegk</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mrs. Lillian Watson</b>		
ADDRESS <b>(Same)</b>					
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>1. Atherosclerotic Heart Disease - Coronary Insufficiency</b> <b>acute Myocardial Infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF <b>2. Essential Hypertension</b>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>420.1 II</b>					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No)					
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <b>July 1964</b> to <b>May 2, 1968</b> , that (I) (we) last saw the deceased alive on <b>May 2, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald W. Mintzer</b>			23B. DATE SIGNED <b>May 3, 1968</b>		
23C. PHYSICIAN'S NAME (Type) <b>Donald W. Mintzer MD</b>			23D. ADDRESS <b>3009 Evergreen Avenue, Balto. Md. 21214</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/68</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Thomas Epis. Church Cem.</b>	
24D. LOCATION <b>Garrison, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	
24G. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		24H. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

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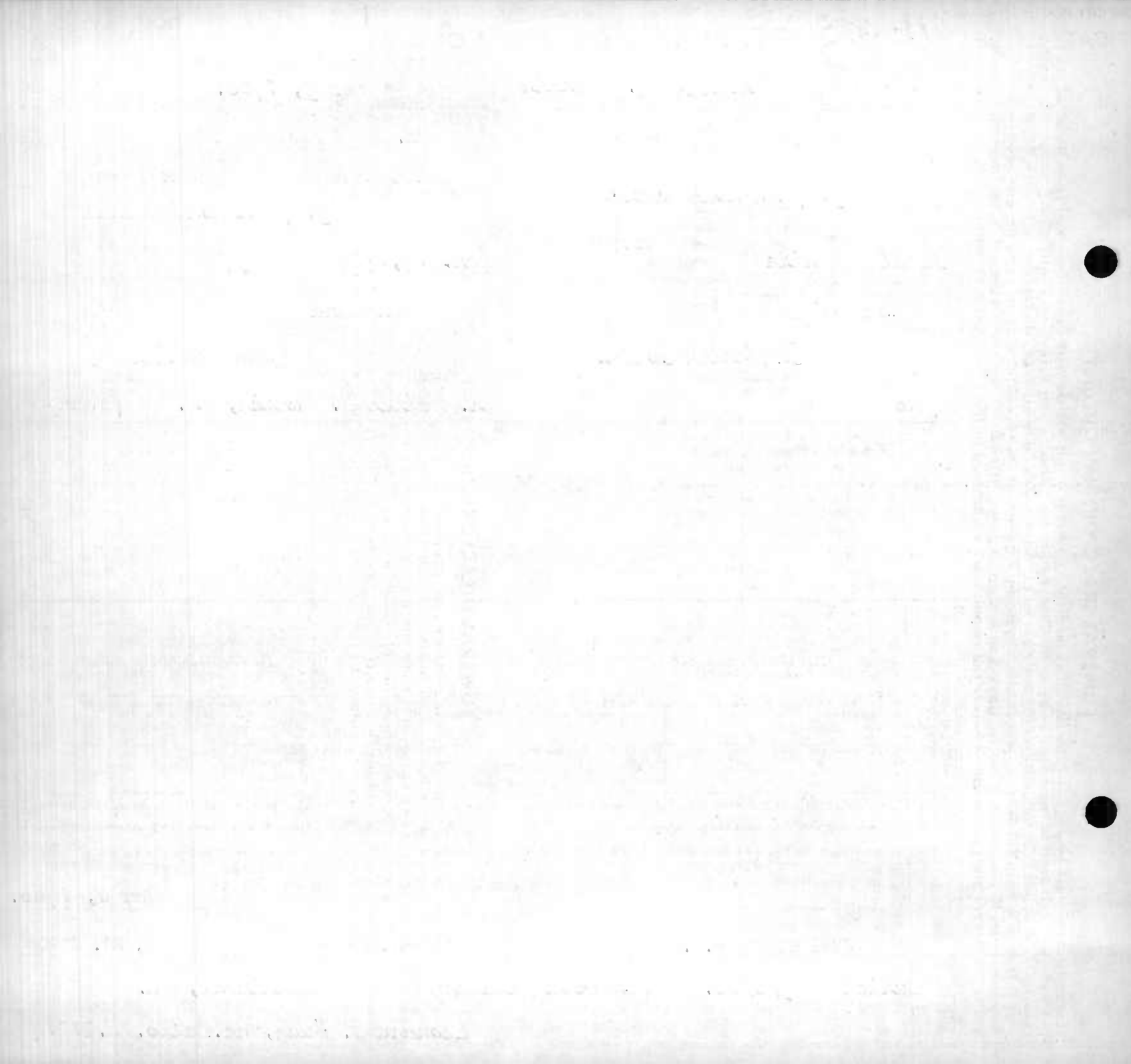
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 4741</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>S-165</b></span> <span><b>68- 4741</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>Springer Robert W.</b>			2. DATE AND HOUR OF DEATH <b>5/5/68 1:00</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>USPHS Hospital</b>			C. CITY OR TOWN <b>Balto</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>2X</b>			E. STREET AND NUMBER <b>1676 Northbourne Rd</b>		
5. SEX <b>M</b>	6. RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/28/00</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Officer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Pa</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>William Springer</b>		
14. MOTHER'S MAIDEN NAME <b>Anna Ramage</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1924---1953</b>		
16. SOCIAL SECURITY NO. <b>168 098433</b>			17. INFORMANT <b>T. Judas mb</b>		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarct</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>AS CVD</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/21</b> 19 <b>68</b> to <b>5/5</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5/5/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Peter P. Judas Jr. M.D.</b>			23B. DATE SIGNED <b>5/5/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Peter P. Judas Jr. M.D.</b>
23D. ADDRESS <b>U.S.P.H.H. Balto. Md.</b>			23E. DEGREE <b>DEGREE</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/8/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem.</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. STATE <b>(State)</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>M-635</i>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <i>68-4742</i>			
1. NAME OF DECEASED (Type or Print) <i>Margaret E. Martin</i>				2. DATE AND HOUR OF DEATH <i>May 5, 1968.</i> <i>10 A.M.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>5107 Anthony Avenue</i>				A. STATE <i>Md.</i> B. COUNTY							
				C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <i>5107 Anthony Avenue</i>							
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 14, 1914</i>		9. AGE (In years lost birthday) <i>54</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frederick Joebus</i>				14. MOTHER'S MAIDEN NAME <i>Emma Bullen</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Walter S. Martin, Jr.</i>				ADDRESS <i>(Same)</i>	
18. <i>348.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Progressive Spinal muscular atrophy</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>18 months</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <i>1-3-1968</i> to <i>5-5-1968</i> , that (I) (we) last saw the deceased alive on <i>5-3-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Juri Hinnno</i>				DEGREE <i>M.D.</i> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>May 6, 1968.</i>			
23C. PHYSICIAN'S NAME (Type) <i>JURI HINNO, M.D.</i>				23D. ADDRESS <i>5002 Frankford Avenue, Baltimore, Md. 21206</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/8/68.</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 6 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>Balto. Md. 21214</i>					

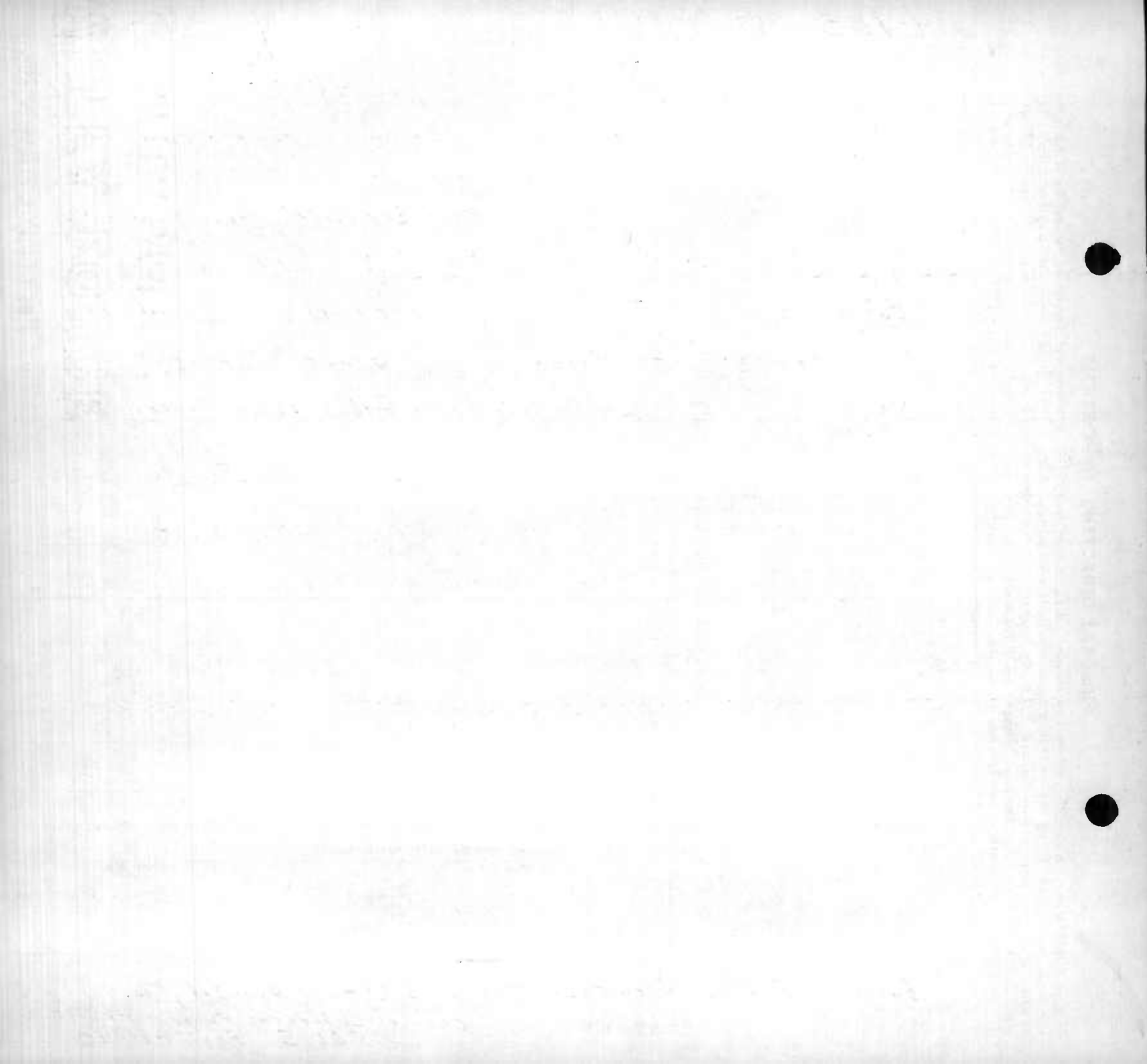


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

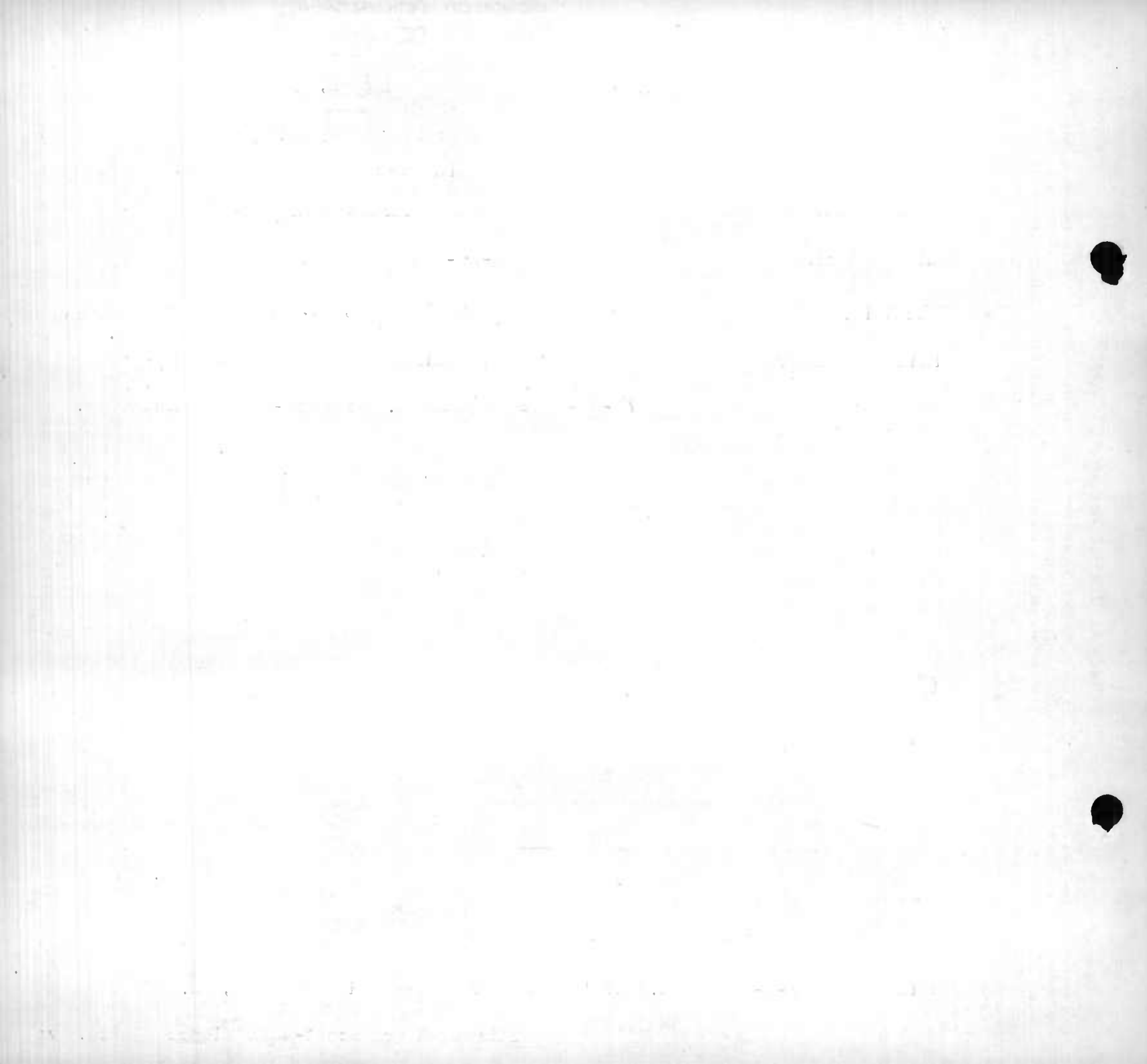
H-163		68- 4743		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 4743	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Ann Shirley Hubbard</i>			
2. DATE AND HOUR OF DEATH <i>4/29/68 9:10 P.M.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 SINAI HOSPITAL</i>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX <i>F</i>				6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Barmaid</i>				10B. KIND OF BUSINESS OR INDUSTRY —		8. DATE OF BIRTH <i>May 17, 1948</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>				9. AGE (In years last birthday) <i>19</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Forrest Armstrong</i>				14. MOTHER'S MAIDEN NAME <i>Grace Parsley</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>214-54-2071</i>		17. INFORMANT <i>Grace Gibbs</i>	
18. <i>370.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CHRONIC RENAL FAILURE (UREMIA)</i> (B) <i>MALIGNANT HYPERTENSION 12 yrs</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>CHRONIC BILATERAL RENOVASCULAR DISEASE</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>600.0 II</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (t) (this hospital) attended the deceased from <i>3/4</i> 19 <i>68</i> to <i>4/29</i> 19 <i>68</i> , that (t) (we) last saw the deceased alive on <i>4/29</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Richard Kator M.D.</i>				23B. DATE SIGNED <i>4/29</i>		23C. PHYSICIAN'S NAME (Type) <i>Richard Kator M.D.</i>	
23D. ADDRESS <i>1501 E. Fort Avenue</i>				23E. DEGREE		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/3/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Anne Arundel, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 6 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Charles E. Stevens Funeral Home, Inc.</i>		25D. ADDRESS <i>1501 E. Fort Avenue</i>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-356		68-4744		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-4744	
BIRTH NO.					1				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
James Edward Dettmore					May 5, 1968				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE B. COUNTY				
Maryland Baltimore					C. CITY OR TOWN D. INSIDE CITY LIMITS				
Baltimore					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER					4313 Chatham Road				
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
Male		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		1-30-1892		76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Machinist				Wilkes Barre, Pa.		USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
William Dettmore					Dailey				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
Yes WW 1					178-22-3315				
17. INFORMANT					ADDRESS				
Donald E. Dettmore					-4313 Chatham Rd.				
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					Anterior Septal Heart Disease				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES					(B) Hypertension				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) Generalized Arterio Sclerosis				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Dec. 10 - 65 19 to May 5 1968, that (I) last saw the deceased alive on Jan. 12 - 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Earl L. Chambers					5/6/68				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Earl L. Chambers					4108 Liberty Hts Balto - Ind				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		5-9-1968		St. Mary's Cemetery		Wilkes Barre, Pa.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAY 6 1968		Robert E. Farley, M.D.		Ellsworth Armacost		4600 Liberty Hghts. Ave			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 2em;">X</span>	68- 4745
<b>5-540</b> BIRTH NO.		<b>68- 4745</b> 1. NAME OF DECEASED (Type or Print) <b>Charles Wheatley Smiley</b>		2. DATE AND HOUR OF DEATH <b>May 3, 1968</b> <span style="float: right;"><b>9:15 A</b> M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold; font-size: 1.2em;">             CERTIFICATE AMENDED           </div> <div style="text-align: center; margin-top: 10px;"> <b>90</b>  <b>ANDERSON NURSING HOME</b> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>902 Breezewich Road 21204</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-15-1869</b>	9. AGE (In years last birthday) <b>98 yrs.</b>	If Under 1 Yr. Months; Days    If Under 24 Hrs. Hours    Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeping</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>William Smiley</b>		14. MOTHER'S MAIDEN NAME <b>Isabella Greenwood</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-12-3969</b>		17. INFORMANT <b>Alice E. Smiley-902 Breezewich Rd. 21204</b>	
<b>18. CAUSE OF DEATH</b>					
<b>440.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
<b>450.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 18 1965</b> to <b>May 3 1968</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>3/12 1968</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>J. Frank Supplee, Jr.</b>				23B. DATE SIGNED <b>5/3/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Frank Supplee, Jr.</b>				23D. ADDRESS <b>1616 St Paul St., Balt 2, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-6-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Ellsworth Armacost-4600 Liberty Hgts. Ave</b>			

VS 153 re names of parents

FILE

1. Joseph Smith  
2. Mary Smith

1. Joseph Smith

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>M-560</b>		68- 4746		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>68- 4746</b>	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Annie Maria Monroe</b>			
2. DATE AND HOUR OF DEATH <b>MAY 3, 1968 7:30 P. M.</b>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION <b>2417 SO. PACA Street</b>		(If not in hospital or institution, give street address or location) <b>Baltimore, Md.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>2417 SO. PACA Street.</b>		5. SEX <b>Female</b>		6. RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify) married</b>	
8. DATE OF BIRTH <b>DEC 26, 1879</b>		9. AGE (In years last birthday) <b>87 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		11. BIRTHPLACE (State or foreign country) <b>Md, Baltimore Co</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward SAVAGE</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Cassell</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>230-30-9771</b>		17. INFORMANT <b>Charles A. Monroe</b>		ADDRESS <b>SAME</b>		18. <b>412.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Arterio-sclerotic Heart</b> (A) DUE TO <b>Hypertensive Heart</b> (B) DUE TO <b>Senility</b> (C) DUE TO	
INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs.</b>		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>420.0 II</b>		20. CAUSE OF DEATH <b>Arterio-sclerotic Heart</b>		21. INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 1968</b> to <b>MAY 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>MAY 19, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Jerry C. Luck</b>		23B. DATE SIGNED <b>MAY 3, 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>Jerry C. Luck</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/9/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>6614 Borne</b>	

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1  
D-200 68-4747 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-4747

BIRTH NO.		1. NAME OF DECEASED (Type or Print) PAUL DIGGS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 4, 1968 Hour 5:45 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1725 Ellsworth Avenue Street		3. DATE PRONOUNCED DEAD Month Day Year May 4, 1968 Hour 5:45 P. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH Nov 11, 1906	10. AGE (In years last birthday) 61	11. BIRTHPLACE (State or foreign country) Smithfield Va.		E. STREET AND NUMBER 1725 Ellsworth Avenue Street	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME George Diggs		14. MOTHER'S MAIDEN NAME Mary Thornton	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY		17. SOCIAL SECURITY NO.	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		19. SOCIAL SECURITY NO.		20. INFORMANT Alice Diggs 1725 Ellsworth St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 150X I Carcinoma of Esophagus		CAUSE OF DEATH Carcinoma of Esophagus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 150X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:					
22A. DATE OF OPERATION		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22C. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-5-68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 6 1968		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Arbutus Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 6 1968		25B. NAME OF REGISTRAR E. F. Johnson	
25C. FUNERAL DIRECTOR Frank T. Elicker		25D. ADDRESS 1129 N. Carroll St.			

— Mrs —

— Mrs —

Smithfield Co.  
N.Y.

My dear  
Mary  
My dear  
Mary

WATKINS

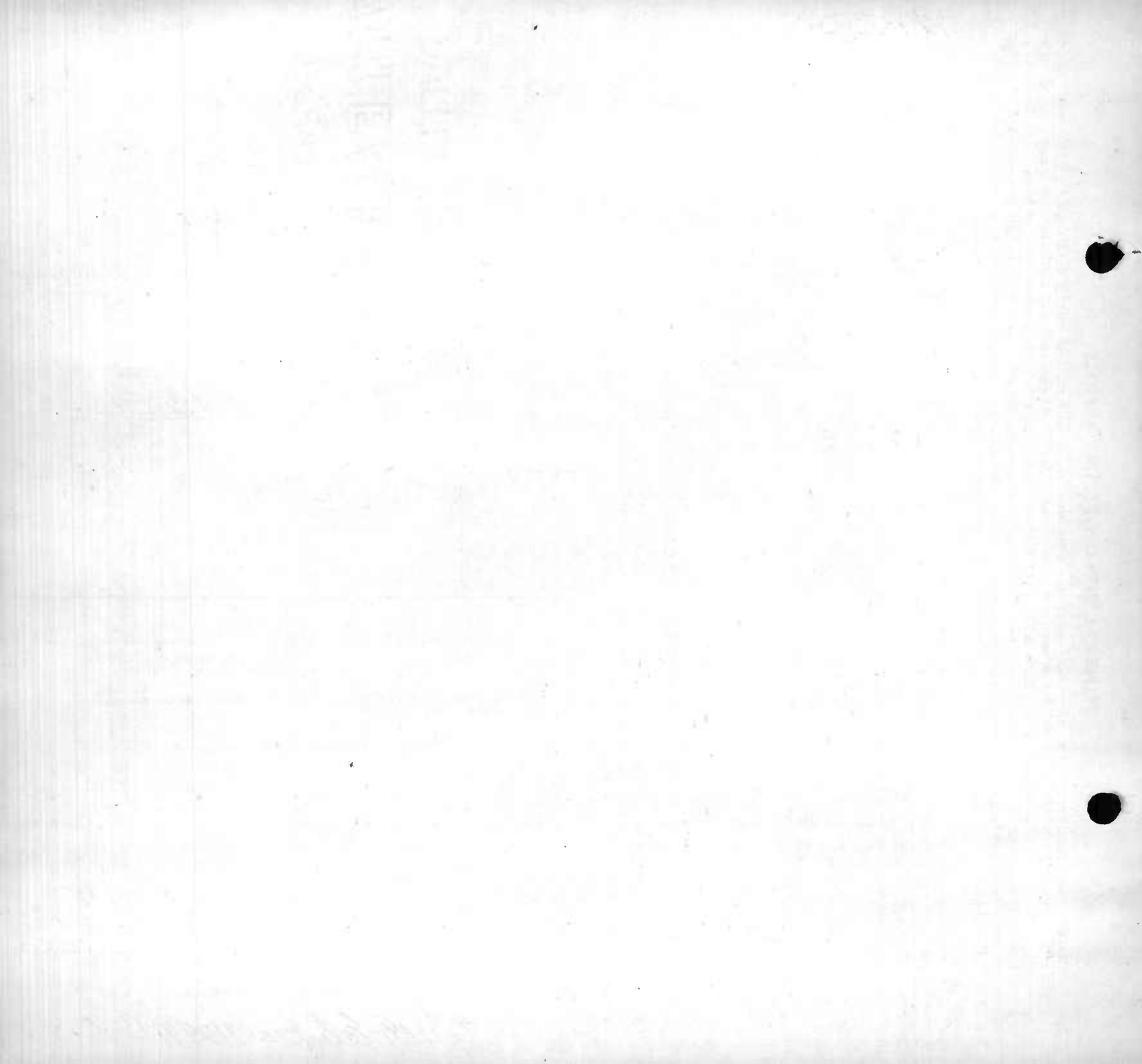
WATKINS

Smithfield Co. N.Y.  
My dear Mary  
My dear Mary

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4748	
<div style="display: flex; justify-content: space-between;"> <span>17-300</span> <span>68- 4748</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Edward Moody</i>		2. DATE AND HOUR OF DEATH <i>May 2, 1968</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>3514 Terra Firma Road</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>Caucas</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		B. DATE OF BIRTH <i>April 18, 1902</i> 9. AGE (In years lost birthday) <i>66</i>	
13. FATHER'S NAME <i>Frank Moody</i>		14. MOTHER'S MAIDEN NAME <i>Lelia Garrett</i>		11. BIRTHPLACE (State or foreign country) <i>Richmond, Va.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World War II</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Willie A. Moody</i>	
18. <i>1978</i> I		CAUSE OF DEATH		ADDRESS <i>2514 Terra Firma Road</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CARCINOMA OF LIVER</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>UNKNOWN</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
156.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/2/1968</i> to <i>5/2/1968</i> , that (I) (we) last saw the deceased alive on <i>April 25, 1968</i> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John S. Braxton Jr.</i>		23B. DATE SIGNED <i>5/3/68</i>		23C. PHYSICIAN'S NAME (Type) <i>John S. Braxton Jr.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/7/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Bald. Natl. Cemetery</i>	
24D. LOCATION <i>5501 Frederick Ave</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 6 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>John P. Edickson</i>		25D. ADDRESS <i>11297 Carlin St</i>		25E. ADDRESS <i>11297 Carlin St</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4749</b>	
BIRTH NO. <b>B-250</b>		68-4749		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>RHODIE BECKHAM</b>			2. DATE AND HOUR OF DEATH <b>5-2-68</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>CITY OF BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1535 NORTH WOLFE STREET</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-20-98</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beloved</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Alexander Virginia</b>	
13. FATHER'S NAME <b>JOSEPH BECKHAM</b>		14. MOTHER'S MAIDEN NAME <b>MATTIE WILSON</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Evelyn Beckham</b>	
18. <b>403 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>446 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Unknown</b> (B) <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Hypertensive nephrosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>72 months</b>	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 1 1968</b> to <b>May 2 1968</b> , that (I) (we) last saw the deceased alive on <b>9 PM May 1 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Allen B. Kaiser</b>				23B. DATE SIGNED <b>5/2/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Allen B. Kaiser</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 7/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Ad. County Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Mietra E. Elukh</b>			
25D. ADDRESS <b>1129 N. Charles St</b>					

Private Office  
Alden D. Warner  
Cass & Jones

May 1 1881  
X

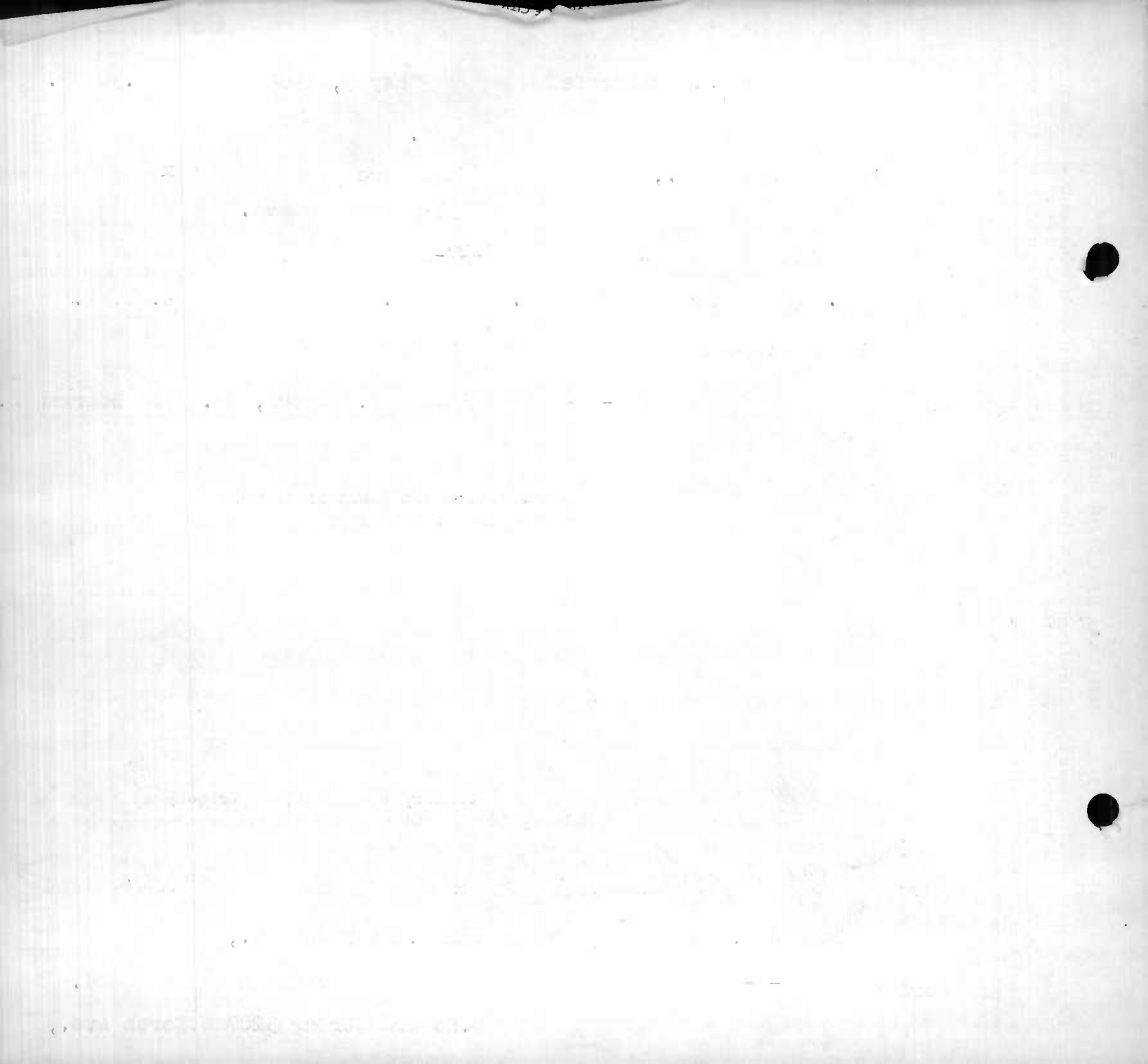
Hyphomys rufipes (Gün.)  
Warner

Warner

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">H-432 68-4750</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">68-4750</span>	
1. NAME OF DECEASED (Type or Print) <b>Henry C. Holtgreffe</b>				2. DATE AND HOUR OF DEATH <b>May 3, 1968 9.30 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3726 Boarman Ave.,</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3726 Boarman Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-20-1881</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Arundel Meat Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Holtgreffe</b>				14. MOTHER'S MAIDEN NAME <b>Louise Winkel</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-05-4741</b>		17. INFORMANT ADDRESS <b>William H. Wunder, Sr. 3726 Boarman A.</b>			
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>Arteriosclerotic heart <del>fi</del> disease and ulcers of both legs</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.0 II</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>January 6 19 67</b> to <b>February 24 19 68</b> , that (I) (we) last saw the deceased alive on <b>February 24 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Donald B. Hebb M.D.</b> <i>Michael K. Ferguson M.D.</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/6/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Donald B. Hebb</b>				23D. ADDRESS <b>111 W. Monument St.,</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5-7-1968</b>	24C. NAME of CEMETERY or CREMATORY <b>Woodlawn</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>G. Howard Strong 3207 W. North Ave.,</b>			

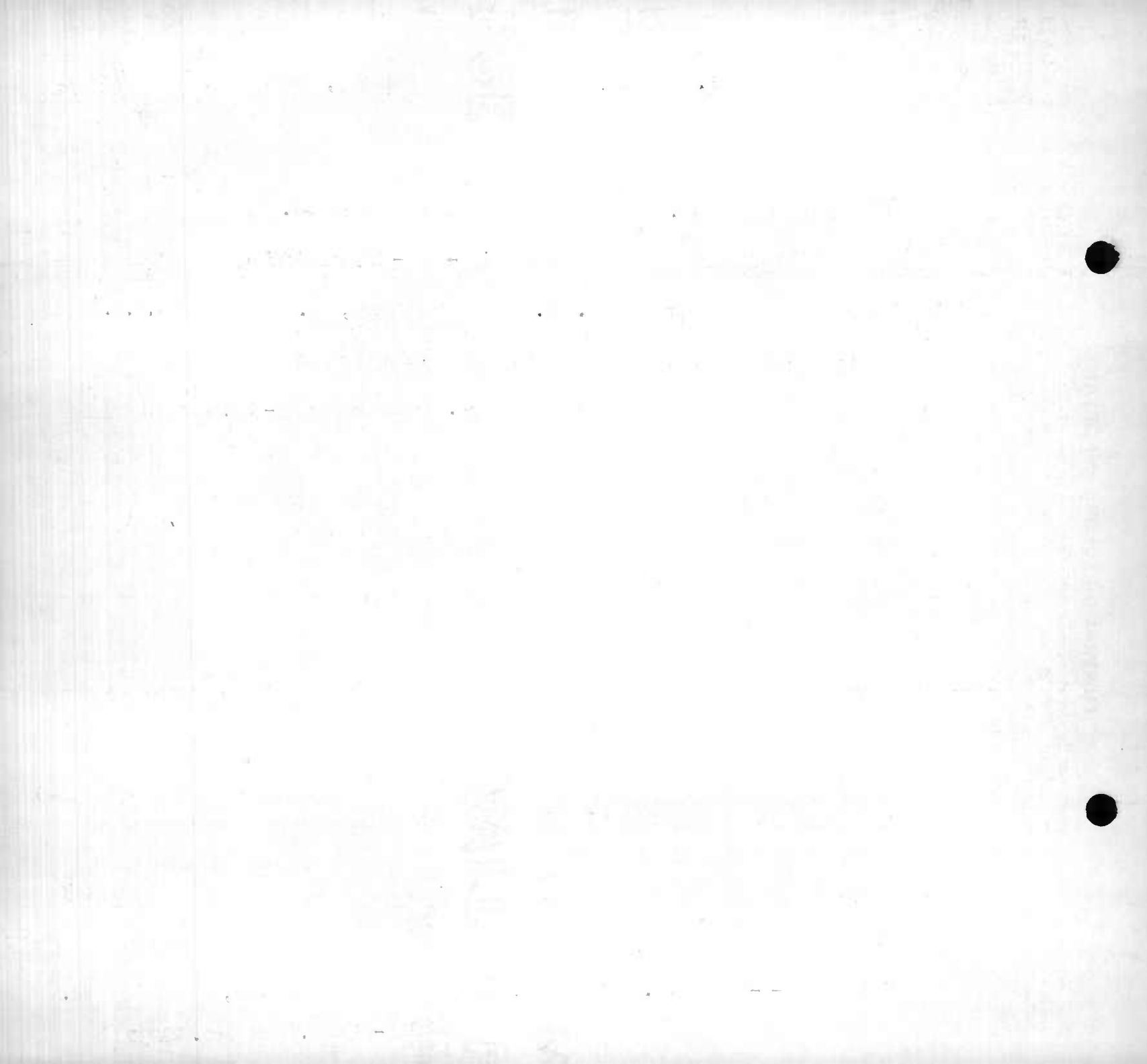




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4751	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Vernon L. Lepson</b>	
2. DATE AND HOUR OF DEATH <b>May 3, 1968</b>				430 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1612 Winford Rd.</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>10-14-1894</b> 9. AGE (In years last birthday) <b>73</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipefitter</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Elec. Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Lepson</b>				14. MOTHER'S MAIDEN NAME <b>Ella Hartman</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Grace Lepson - same as # 4</b>				ADDRESS	
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CA of colon &amp; metastasis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arterio Sclerosis generalized</b> <b>Cerebral Infarction</b> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>5 yrs</b> <b>rela</b>	
19. <b>153.8 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____					
19A. DATE OF OPERATION <b>5/3/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/10</b> 19 <b>67</b> to <b>5/3</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5/3</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph B. Laukaitis MD</b>				23B. DATE SIGNED <b>5/3/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH B. LAUKAITIS MD</b>				23D. ADDRESS <b>679 Washington Blvd Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-6-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>McCully- 130 E. Fort Ace. 21230</b>	



## P-350 68-4752 CERTIFICATE OF DEATH

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Peyton, James

2. DATE AND HOUR OF DEATH

5/1/68

3 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4940 Eastern Ave.

Baltimore, Maryland # 21224

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore Co

53.00

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Essex (21)

YES ☐NO ☒

E. STREET AND NUMBER

158 Silver Lane

5. SEX

6. RACE

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years lost birthday)

If Under 1 Yr. Months

If Under 24 Hrs. Days

Male

White

WIDOWED ☐ Sep. DIVORCED ☒

3-9-00

68

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Laborer

Farm

Virginia

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Edmund Peyton

Mrs. Mary Breeden

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

No

214-14-7757-A

BCH: Records 4940 Eastern Ave. Baltimore, Md.

# 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

Chronic VTI, Pericarditis, Myocarditis

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(B) Probable Septic 2° VTI.

(C) DUE TO, OR AS A CONSEQUENCE OF:

609X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

1/12/68

Chronic VTI

YES

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

(Month) (Day) (Year) (Hour)

While At Work ☐Not While At Work ☐

22. I certify that (I) (this hospital) attended the deceased from 1/12/68 19 to 5/1/68 19, that (I) (we) last saw the deceased alive on 5/1/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

5/1/68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

A.E. Smith MD.

Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

5/6/68

Poplar Grove Meth Cemetery

Baltimore Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

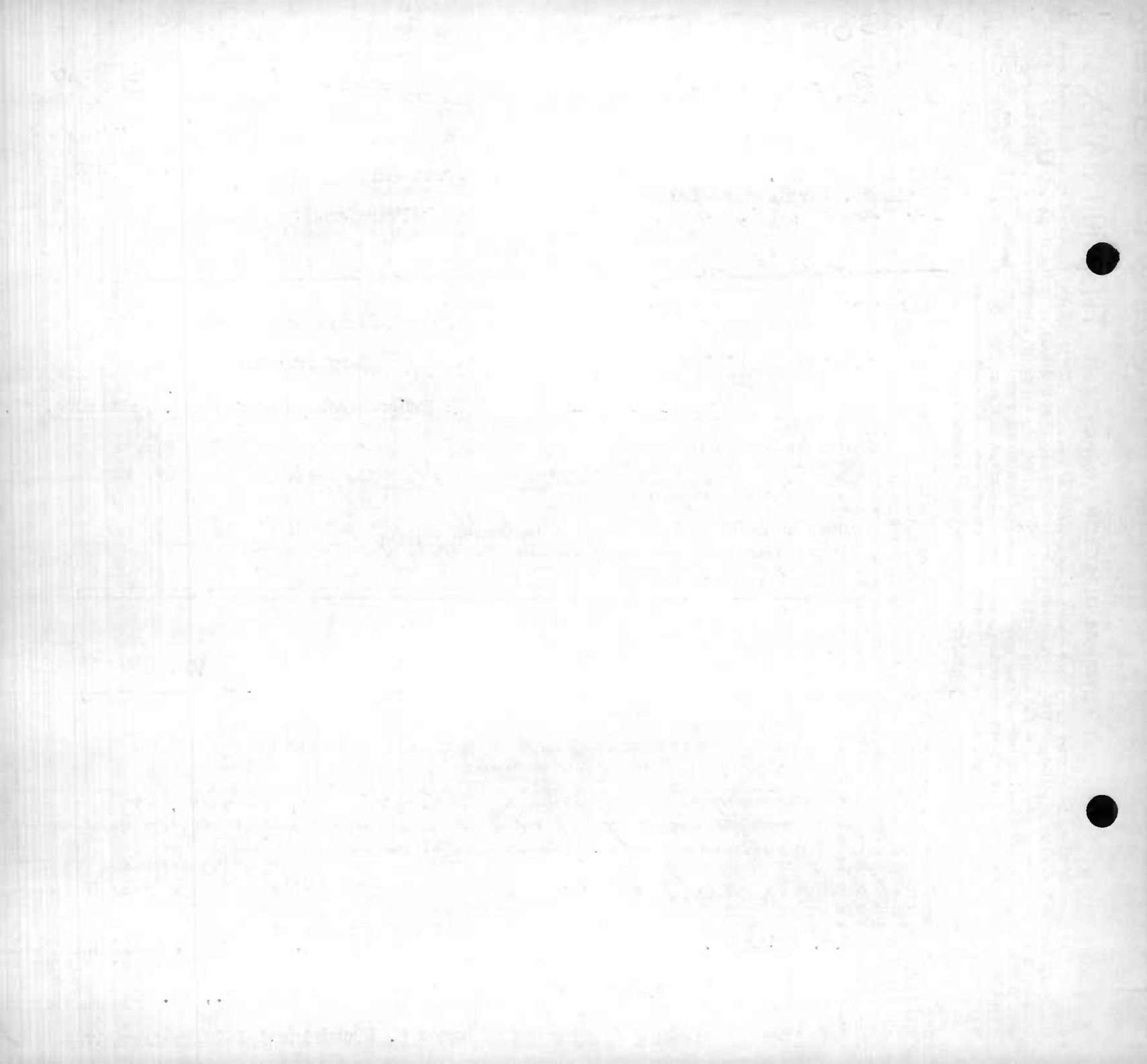
25C. FUNERAL DIRECTOR

ADDRESS

MAY 7 1968

Robert E. Fisher, MD

James E. Bruzdinski 1407 Eastern Ave.



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N-552

68-4753

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-4753

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>IRVIN B. NUNAMAKER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 2, 1968</b>		Hour <b>2:10 P.M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CITY HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 2, 1968</b>		Hour <b>2:10 P.M.</b>
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>February 5, 1943</b>		10. AGE (In years last birthday) <b>25</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Nunamaker</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Ellenberger</b>
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Essex (21)</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go on or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>212 40 3662</b>		18. INFORMANT <b>William Nunamaker</b> Same
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>5-3-68</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-6-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Ebenezer Meth. Ch. Cemetery Baltimore Co., Md.</b>
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>
25C. FUNERAL DIRECTOR <b>James E. Bruzdinski</b>		25D. ADDRESS <b>1407 Eastern Ave.</b>		

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4754

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>IRMA HURLEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 3, 1968</b> Hour <b>4:35 P.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>600 Cherry Crest Road</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year <b>May 3, 1968</b> Hour <b>4:35 P.</b> M.	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>1912 1/12</b>		10. AGE (In years last birthday) <b>55</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JAMES HENDRICKS</b>		14. MOTHER'S MAIDEN NAME <b>DELIA BROWN</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH <b>493 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchial Asthma</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5-4-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-7-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>ARBUTUS MEM PK.</b>		24D. LOCATION (City, town, or county) (State) <b>ARBUTUS MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Ronald E. Farley</b>	
25C. FUNERAL DIRECTOR <b>I. L. Brown &amp; Son</b>		ADDRESS <b>123 W. MONTGOMERY ST.</b>	

Pennsylvania

James Hendricks

Devin Brown

Edward V. Hursey and others

MAILED

2007

Bureau 30-7-68. Address Memphis, Tennessee

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 4755 CERTIFICATE OF DEATH

REG. NO. 68- 4755

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Trebstad, Julia</i>		2. DATE AND HOUR OF DEATH <i>5/3/68 7:05 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Co</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>36 Franklin Square Hosp</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>6313 Frederick Ave Catonsville</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/27/180</i>	9. AGE (In years lost birthday) <i>87</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (State or foreign country) <i>Norway</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>unknown</i>			14. MOTHER'S MAIDEN NAME <i>unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>unknown</i>	17. INFORMANT ADDRESS		
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis</i> (C) DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary artery disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Yes</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>4-22-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>II</i>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4-26-68</i> to <i>5-3-68</i> , that (I) <i>we</i> last saw the deceased alive on <i>5-3-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nak Joong Im</i>			23B. DATE SIGNED <i>5-3-68</i>		
23C. PHYSICIAN'S NAME (Type) <i>Nak Joong Im</i>			23D. ADDRESS <i>Franklin Square Hosp</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>5/6/68 BURIAL</i>		24B. DATE <i>MAY 7 1968</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET</i>	
24D. LOCATION <i>BALTIMORE MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 7 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fadden</i>	
25C. FUNERAL DIRECTOR <i>E.S. MacNabb</i>		25D. ADDRESS <i>301 Frederick Rd Balto 21208 Md</i>			

21/10/80 H.T. CIVIC

Baltimore

18 May 1981

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68- 4756</b>	
BIRTH NO. <b>m-223</b>		68- 4756	
1. NAME OF DECEASED (Type or Print) <b>NEE SILVERMAN MCHESTNEY, GERTRUDE</b>		2. DATE AND HOUR OF DEATH <b>4 MAY 1968 12: 40 AM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/13/12</b> 9. AGE (In years last birthday) <b>55</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ISADORE SILVERMAN</b>		14. MOTHER'S MAIDEN NAME <b>TILLIE BARRE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md.</b>			
18. <b>431.0 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>INTRACEREBRAL HEMORRHAGE 4 HRS.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10-15 YRS</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>331.X II HYPERTENSION, MULTIPLE SCLEROSIS</b>			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>3 MAY 1968</b> to <b>4 MAY 1968</b> , that (I) ( <del>last</del> ) saw the deceased alive on <b>4 MAY 1968</b> and that in (my) ( <del>four</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) (did) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <b>Russell D Hicks</b> DEGREE		23B. DATE SIGNED <b>4 MAY 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>RUSSELL D. HICKS</b>		23D. ADDRESS <b>BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>5/5/68</b>	24C. NAME of CEMETERY or CREMATORY <b>Chizub Amuno</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS INC.</b>		25D. ADDRESS <b>6010 Reist Rd.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased, was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-654		68- 4757		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 4757	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ANNA CARMEL</b>		2. DATE AND HOUR OF DEATH <b>2 MAY 1968 17:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balti Co</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>91 LEVINDALE HEBREW HOME + INFIRMARY</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>130 SLADE AVENUE #21208</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>85</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH COLVIN</b>		14. MOTHER'S MAIDEN NAME <b>RACHAEL ?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MR. JOSEPH CARMEL, 130 SLADE AVE., APT. 619</b>		ADDRESS <b>#21208</b>					
18. <b>485X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>BRONCHO PNEUMONIA</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRONCHO PNEUMONIA</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 wk.</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>491X II ASCVD</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (s) (this hospital) attended the deceased from <b>2/19</b> 19 <b>68</b> to <b>5/2</b> 19 <b>68</b> , that (s) (we) last saw the deceased alive on <b>5/2</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Abe Levy, M.D.</b>		23B. DATE SIGNED <b>5/2/68</b>		23C. PHYSICIAN'S NAME (Type) <b>ABE LEVY</b>			
23D. ADDRESS <b>Sinai Hospital</b>		23E. DEGREE <b>OEGREE</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-5-68</b>		24C. NAME of CEMETERY or CREMATORY <b>MIKRO KODESH-BETH ISRAEL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Sal Heinson &amp; Bros.</b>		ADDRESS <b>6010 Reisterstown Rd - Balto Md</b>	



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-500		68- 4758		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 4758	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Hattie Cohen</b>			
2. DATE AND HOUR OF DEATH <b>5-4-68</b>				10:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI Hospital of BALT.</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>6808 Williamson Ave.</b>							
5. SEX <b>F</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/13/03</b>	9. AGE (In years lost birthday) <b>64</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTH PLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH HOFFMAN</b>				14. MOTHER'S MAIDEN NAME <b>YETTA CARMEL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MICHAEL COHEN</b>		ADDRESS <b>6808 Williamson Ave.</b>	
18. <b>431.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MASSIVE CVA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>intracranial hemorrhage</b> <b>3 days</b>							
(c) <b>Hypertension</b> <b>3 years</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>331X II</b>							
19A. DATE OF OPERATION <b>5-2-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5-2-68</b> to <b>5-4-68</b> , that (I) (we) last saw the deceased alive on <b>5-4-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Martin S. Libekman MD</b>				23B. DATE SIGNED <b>5-4-68</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>MARTIN S. Libekman</b>				23D. ADDRESS <b>SINAI Hospital of BALTIMORE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/5/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>ADATH JESHURUN</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS INC. 6010 Reist Rd.</b>			

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68- 4759 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4759

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HARRY ZUCKERMAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 4, 1968</b> 5:50 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 4, 1968</b> 5:50 A. M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>July 15, 1895</b>		E. STREET AND NUMBER <b>6803 Williamson Street</b>	
10. AGE (In years last birthday) <b>72</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. BIRTH PLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Zukerman</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee</b>	
14B. KIND OF BUSINESS OR INDUSTRY <b>Shoe Co.</b>		15. MOTHER'S MAIDEN NAME <b>Sylvia ?</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs Rachael L. Zuckerman</b>		ADDRESS <b>--Same</b>	
19. <b>E 814.7 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Multiple Traumatic Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>56 ft. N. of Reistertown &amp; Belevvedere Ave/Belevvedere</b>	
22D. TIME OF INJURY (APPROX.) <b>May 3, 1968 1:15 PM</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Pedestrian struck by car</b>		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>5-4-68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/5/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Kovna Cong.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS INC. 6010 Reist. Rd.</b>		25D. ADDRESS	

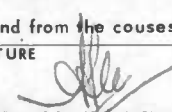
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 4760 CERTIFICATE OF DEATH

REG. NO. 68- 4760

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>William Medley</b>		2. DATE AND HOUR OF DEATH <b>4-25-68</b>   <b>1:45-A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital, Inc.</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore,</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>626 Smithson Street</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-26-26</b>	9. AGE (In years last birthday) <b>42</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>?</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WWII</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mary Lena Medley</b> <b>Teresa Holt - Daughter</b>
18. ADDRESS <b>609 Fulton Avenue</b>					
MEDICAL CERTIFICATION 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>5-11-0 I</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>5-19-0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pleural Effusion</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 24,</b> 19 <b>68</b> to <b>April 25,</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>April 25,</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>4-25-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. KHAN / Dr. TENGCO.</b>				23D. ADDRESS M.D. <b>1514 Division Street Balto., Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/29/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>ST. JOSEPH'S CEMETERY</b>	
24D. LOCATION <b>MORGANZA</b>		24E. CITY, TOWN, OR COUNTY <b>ST. MARY'S</b>		24F. STATE <b>MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>W. CLARKE MATTINGLEY</b>		25C. FUNERAL DIRECTOR <b>LEONARDTOWN, MD.</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4761 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 4761
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>STEPHEN MILLER (PRZYBYLSKI)</b>			2. DATE AND HOUR OF DEATH <b>MAY 3 1968</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>6909 CONLEY STREET</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>6909 CONLEY STREET</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/24/1887</b>	9. AGE (In years lost birthday) <b>80 yrs.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CROWN CORK + SEAL</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD.</b>	
13. FATHER'S NAME <b>STANISLAW PRZYBYLSKI</b>			14. MOTHER'S MAIDEN NAME <b>ANTONINA SZYMANEK</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-01-4738 A</b>		17. INFORMANT <b>MRS. BERTHA SIKORSKY</b>	
				ADDRESS <b>6909 CONLEY ST.</b>	
18. <b>185X I</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
(A) IMMEDIATE CAUSE <b>Cancer of prostate.</b> DUE TO, OR AS A CONSEQUENCE OF: <b>METASTASIS IN LUNG.</b>					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) <b>ANEMIA.</b>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 24 1967</b> to <b>May 3 1968</b> , that (I) (we) last saw the deceased alive on <b>May 3 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rafael A. Santayana</b>				23B. DATE SIGNED <b>MAY 6 - 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>RAPAFEL A. SANTAYANA</b>				23D. ADDRESS <b>6010 EASTERN AVE - BALTO - MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/7/1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary CEMETERY</b>	
				24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b>	
				ADDRESS <b>2525 FLEET ST.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 68- 4762 CERTIFICATE OF DEATH

REG. NO. 68- 4762

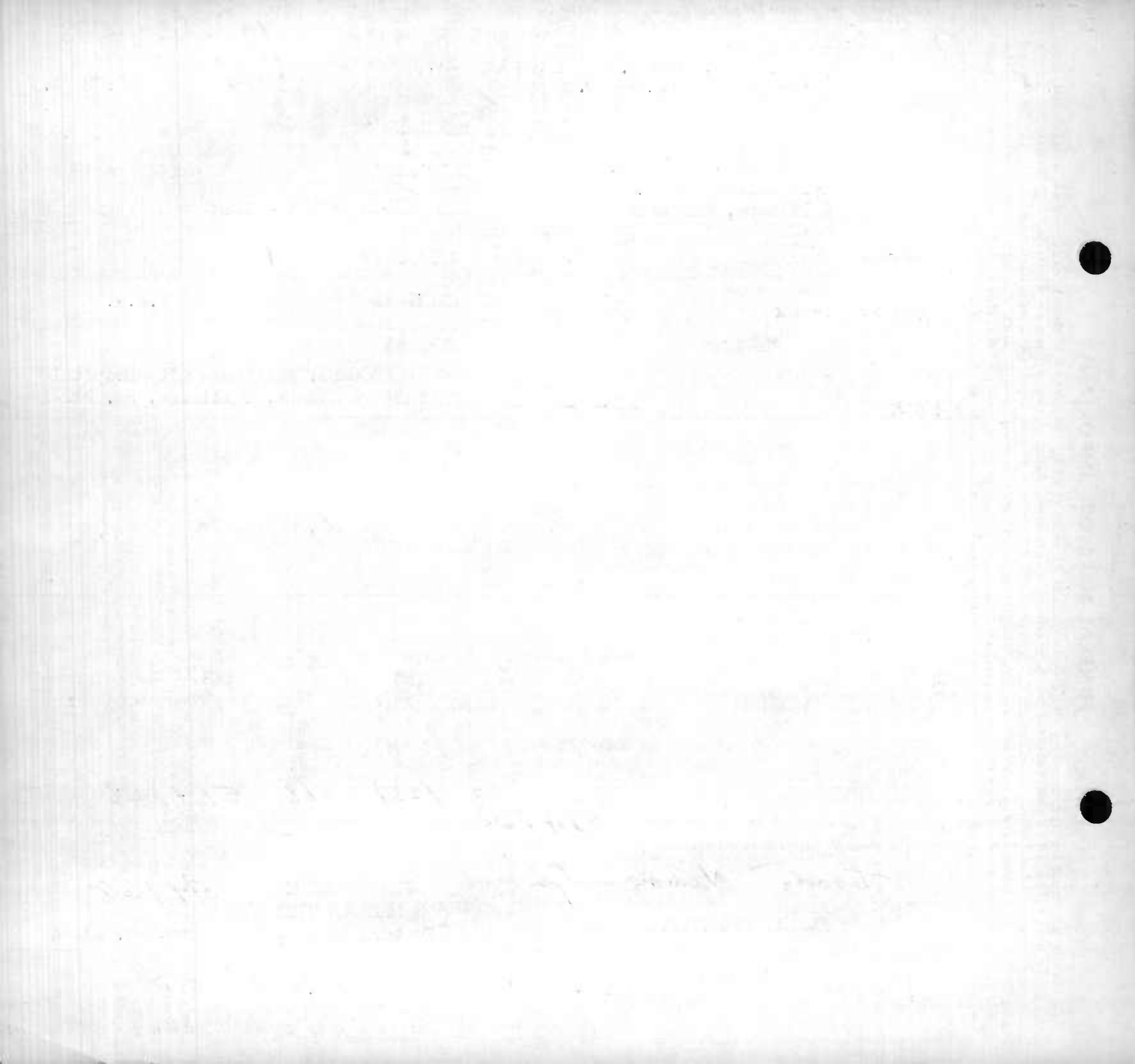
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Cash, George Leonard</i>		2. DATE AND HOUR OF DEATH <i>5/4/68 4:45 A. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>USPHS Hospital Baltimore, Md</i>				A. STATE <i>BALTO. MD.</i>	
				B. COUNTY	
				C. CITY OR TOWN <i>Balt. Md.</i>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>BALTO. MD.</i>	
5. SEX <i>F</i>	6. RACE <i>Ca</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/20/18</i>		9. AGE (In years lost birthday) <i>50</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MGR.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>TIME REC.</i>		11. BIRTHPLACE (State or foreign country) <i>GA</i>	
13. FATHER'S NAME <i>JOHN CASH</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
14. MOTHER'S MAIDEN NAME <i>RUBY OWENS</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WWII</i>		16. SOCIAL SECURITY NO. <i>255-16-2947</i>		17. INFORMANT <i>Chant</i>	
				ADDRESS	
18. <i>162.1 I</i> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <i>Pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <i>Carcinoma of the lung</i> DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
163x II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20. _____		21. _____		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/12/68</i> 19 <i>68</i> to <i>5/4</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5/4</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Herbert D. Baker</i>				23B. DATE SIGNED <i>5/4/68</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>USPHS Balt., Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5/7/68</i>		24C. NAME of CEMETERY or CREMATORY <i>BALTO. NATL.</i>	
				24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 7 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>J.E. CONNELLY SONS</i>	
				ADDRESS <i>300 MAC</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-456 68-4763		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4763	
BIRTH NO. <i>Kellner Lena</i>		1. NAME OF DECEASED (Type or Print) <i>KELLNER, Lena O. CMARY M.)</i>		2. DATE AND HOUR OF DEATH <i>5/4/68 8:00 A. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224</i>		A. STATE <i>MARYLAND</i> B. COUNTY <i>Balto Co</i> <i>53-00</i>	
C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>403 ORIOLE AVENUE - 21224</i>	
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/14/1897</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>VNK</i>		16. SOCIAL SECURITY NO. <i>212-26-0377-A</i>		17. INFORMANT RECORDS: <i>Baltimore City Hospital 4940 Eastern Avenue, Baltimore, Md. 21224</i>	
18. <i>2250 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Tracheal bleeding</i>			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Meningeal hemorrhage</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C).....			
223X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>4/22/68</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>removal</i>	20A. AUTOPSY? (Yes or No) <i>YES</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/25/1968</i> to <i>5/4/68</i> 19 <i>68</i> and that (I) (we) lost saw the deceased alive on <i>5/4/68</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jesada Nimmanitya</i>		23B. DATE SIGNED <i>5/4/68</i>			
23C. PHYSICIAN'S NAME (Type) <i>JESADA NIMMANITYA</i>		23D. ADDRESS <i>BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>5/7/68</i>	24C. NAME OF CEMETERY OR CREMATORY <i>DAK LAWN</i>	24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 7 1968</i>	25B. NAME OF REGISTRAR <i>R. E. Johnson</i>	25C. FUNERAL DIRECTOR ADDRESS <i>J. G. CONNELLY SONS 300 MA...</i>			



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#-160

68- 4764 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

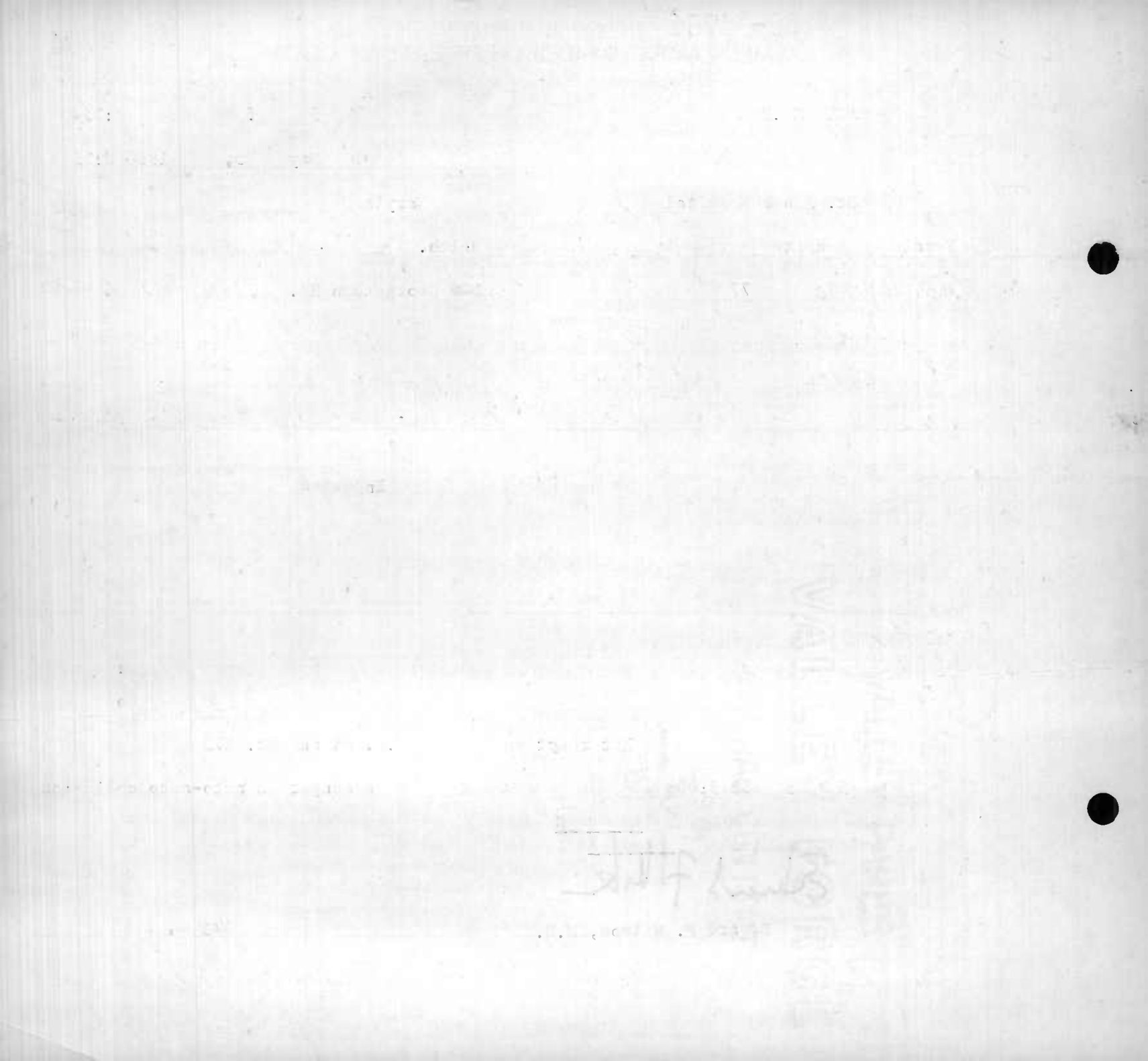
REG. NO.

68- 4764

BIRTH NO.

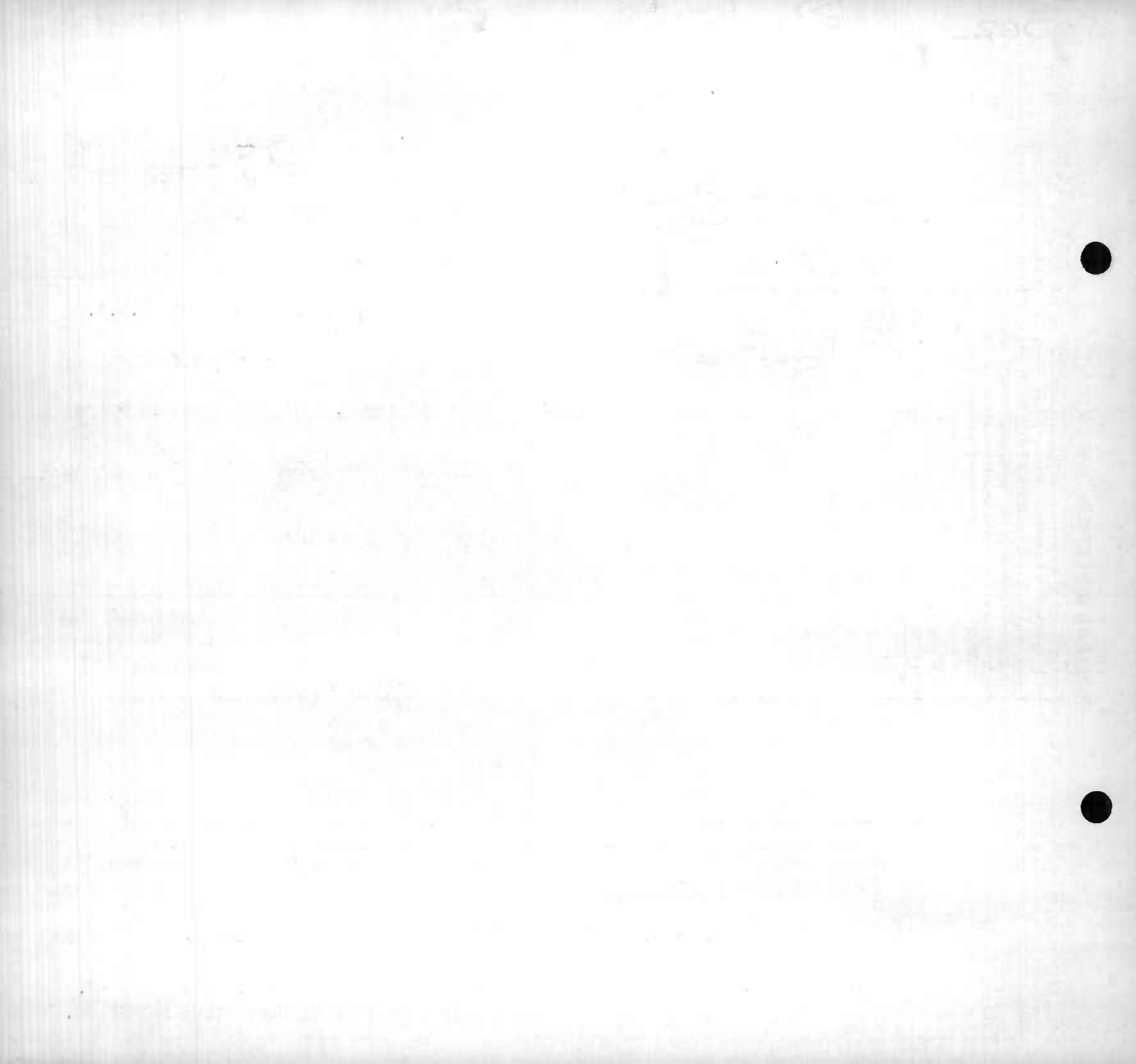
1. NAME OF DECEASED (Type or Print) <b>MARY KEEFER</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 5 5 68 8:25 p M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 5, 1968 8:25 p M.</b>			
6. SEX <b>Female</b>				7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Nov. 13, 1890</b>				10. AGE (In years lost birthday) <b>77</b>		E. STREET AND NUMBER <b>2611 Georgetown Rd. Balt. Md. 21230</b>	
11. BIRTHPLACE (State or foreign country) <b>Ind.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Parks</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				14B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				17. SOCIAL SECURITY NO. <b>-</b>		18. INFORMANT <b>Mrs. Keefer</b>	
19. <b>E 812.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Injuries</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Injuries</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20A. DATE OF OPERATION <b>0</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>E 816.4 II</b>				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Intersection</b>			
22D. TIME OF INJURY (APPROX.) 5 5 68 5:00 p				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>U.S. #1 and Rt. 175</b>	
22F. HOW DID INJURY OCCUR? <b>Passenger in auto-auto collision</b>				21. AUTOPSY? (Yes or No) <b>No</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>May 6, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/9/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Ind.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Cowan &amp; Son, Inc. 901 Hollins St. Balt. Md. 21223</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
Laura M. Stark				May 3 1968				8:20 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE				B. COUNTY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Md.							
611 Highwood Drive				C. CITY OR TOWN				INSIDE CITY LIMITS?			
00				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				611 Highwood Drive 21212							
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. If Under 1 Yr. Months Days	
Female		Cauc.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4-27-1888		80			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Housewife				Housewife				Baltimore, Maryland			
12. CITIZEN OF WHAT COUNTRY?				U.S.A.							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Gasaway Batee				Georgiana Morrison							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				320-10-8998				Mr Stanley B. Hebb 611 Highwood Drive			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				2+ mos			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:				1 yr?			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C).....							
171X II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
								m			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
				White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Apr 29 1968 to May 3 1968, that (I) (we) last saw the deceased alive on Apr 29 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
Frederick J. Vollmer								May 3 1968			
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
FREDERICK J. VOLLMER								6100 YORK RD BALTIMORE MD 21212			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Cremation				5-6-1968		Greenmount Cemetery				Baltimore, City Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
MAY 7 1968				Robert E. Farber				Lassahn Funeral Home 7401 Belair Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4766

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 4766

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mary A. Chow</i>		2. DATE AND HOUR OF DEATH <i>5/5/68 8:30 p. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Century Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Lansdowne</i>	
5. SEX <i>Female</i> 6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Assembly Line work Eastern Products Co.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Lansdowne Md.</i>		9. AGE (In years lost birthday) <i>66</i>	
13. FATHER'S NAME <i>Thomas J. Woods Jr.</i>		14. MOTHER'S MAIDEN NAME <i>Ella M. Thomas</i>		11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>		16. SOCIAL SECURITY NO. <i>217-09-8334</i>		17. INFORMANT <i>Roseanne F. Liscosky</i>	
18. <i>410.9 I</i>		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Cardio-Respiratory Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Ac Myocardial Infarction</i>			
		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Ext. CVA</i>			
		(C) <i>Cerebral Arteriosclerosis</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>420.1 II</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Apr 10 1968</i> to <i>May 5 1968</i> , that (I) (we) last saw the deceased alive on <i>May 5 1968</i> and that in (my) <i>(my)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <del>(did)</del> <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>William Applefeld</i>				23B. DATE SIGNED <i>5/6/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>William Applefeld</i>		23D. ADDRESS <i>6615 Reisterstown Rd</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/8/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Green Haven Cem.</i>	
24D. LOCATION <i>Pitche Hwy. Ellicott City Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>MAY 7 1968</i>			
25A. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25B. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son Inc.</i>			
25C. ADDRESS <i>23 Md.</i>					

Co. 1st Regt. N.Y. 4th Inf.  
March 1862  
Camp near New York City

March 1862

John J. Smith  
Capt. 1st Regt. N.Y. 4th Inf.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

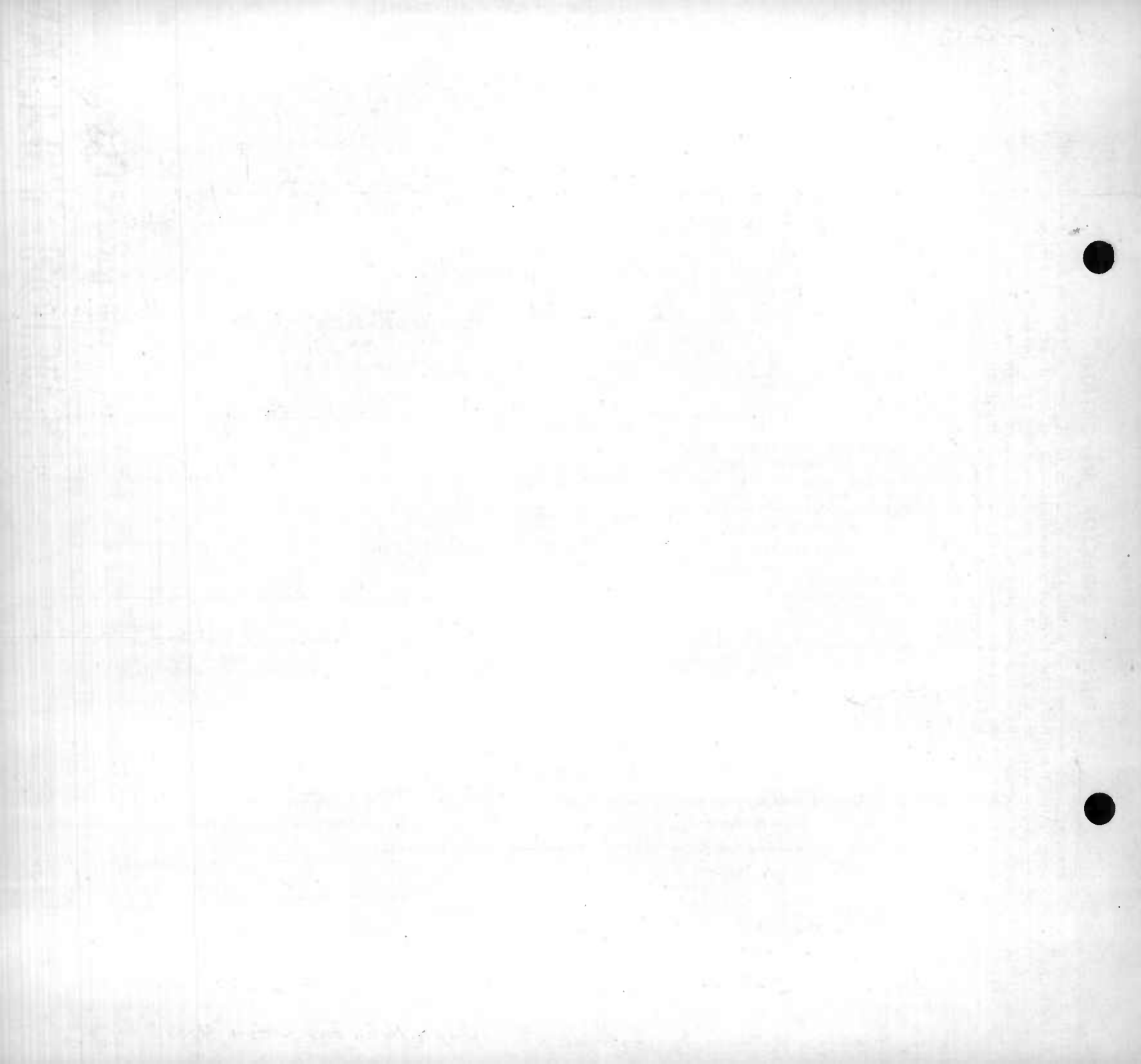
# BALTIMORE CITY HEALTH DEPARTMENT

## 68- 4767 CERTIFICATE OF DEATH

REG. NO.

68- 4767

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WALTER S. NOYES, JR.</b>		2. DATE AND HOUR OF DEATH <b>MAY 5, 1968 5:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 Balto., Md. Park Str.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2033 Shuid Hill Ave</b>		C. CITY OR TOWN <b>Baltimore</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/18/93</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home Bldg.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>American</b>
13. FATHER'S NAME <b>Walter S. Noyes, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>EMMA Clemency Uhler</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Army (WW II)</b>		16. SOCIAL SECURITY NO. <b>220-03-6747</b>		17. INFORMANT <b>Luella Heibel Stricker</b>	
18. <b>203X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Multiple Myeloma</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>multiple myeloma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>203X II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Congestive Heart Failure Unknown</b>					
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 1967</b> to <b>5/5 1968</b> , that (I) (we) last saw the deceased alive on <b>5/5 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>D. W. STEWART</b>				23B. DATE SIGNED <b>5/5/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>D. W. STEWART</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-9-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO. NATIONAL Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. 2129. Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Isom</b>		25C. FUNERAL DIRECTOR <b>John N. Hehn Funeral Home, 4200 Pennington Ave</b>			

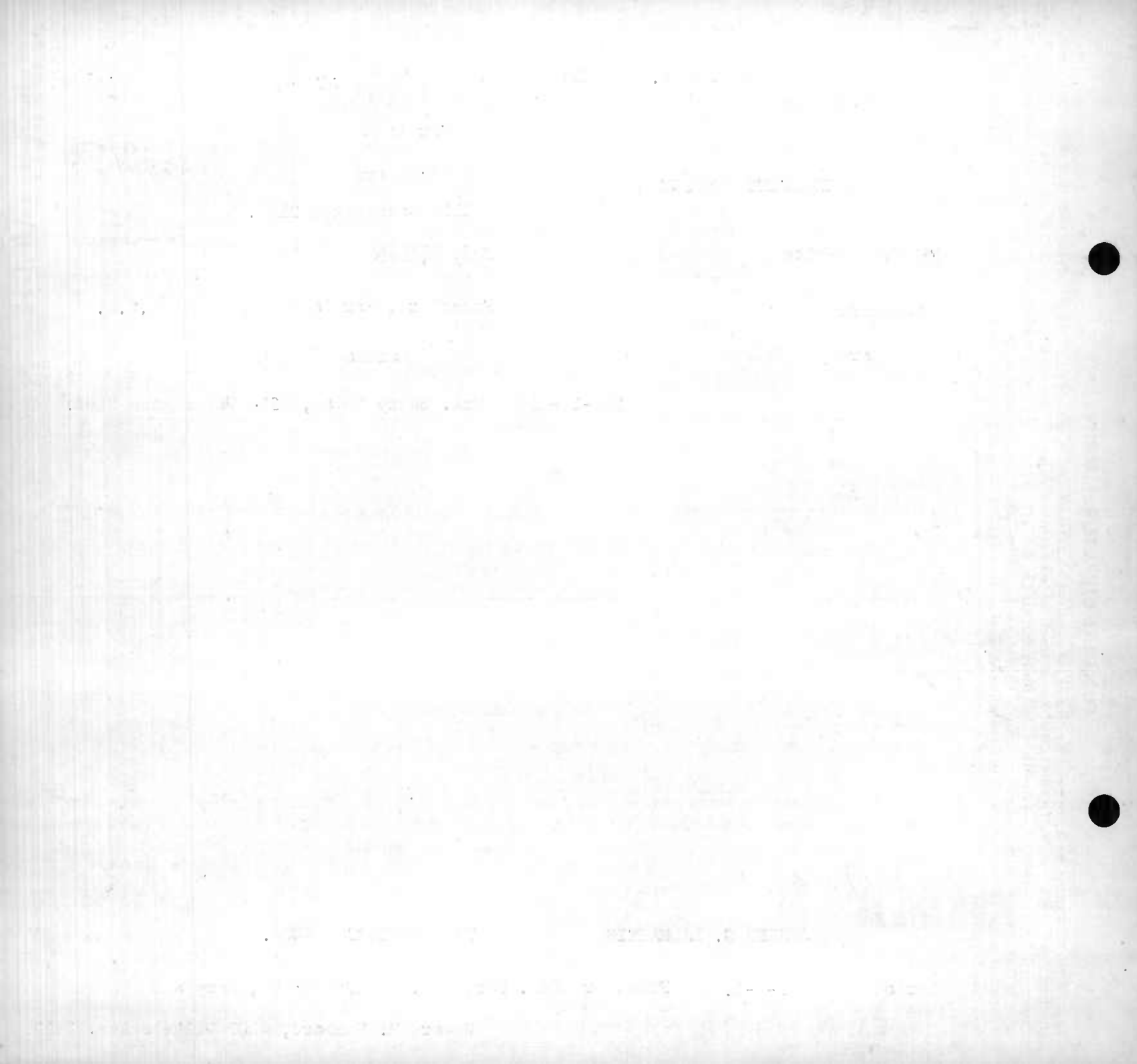




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

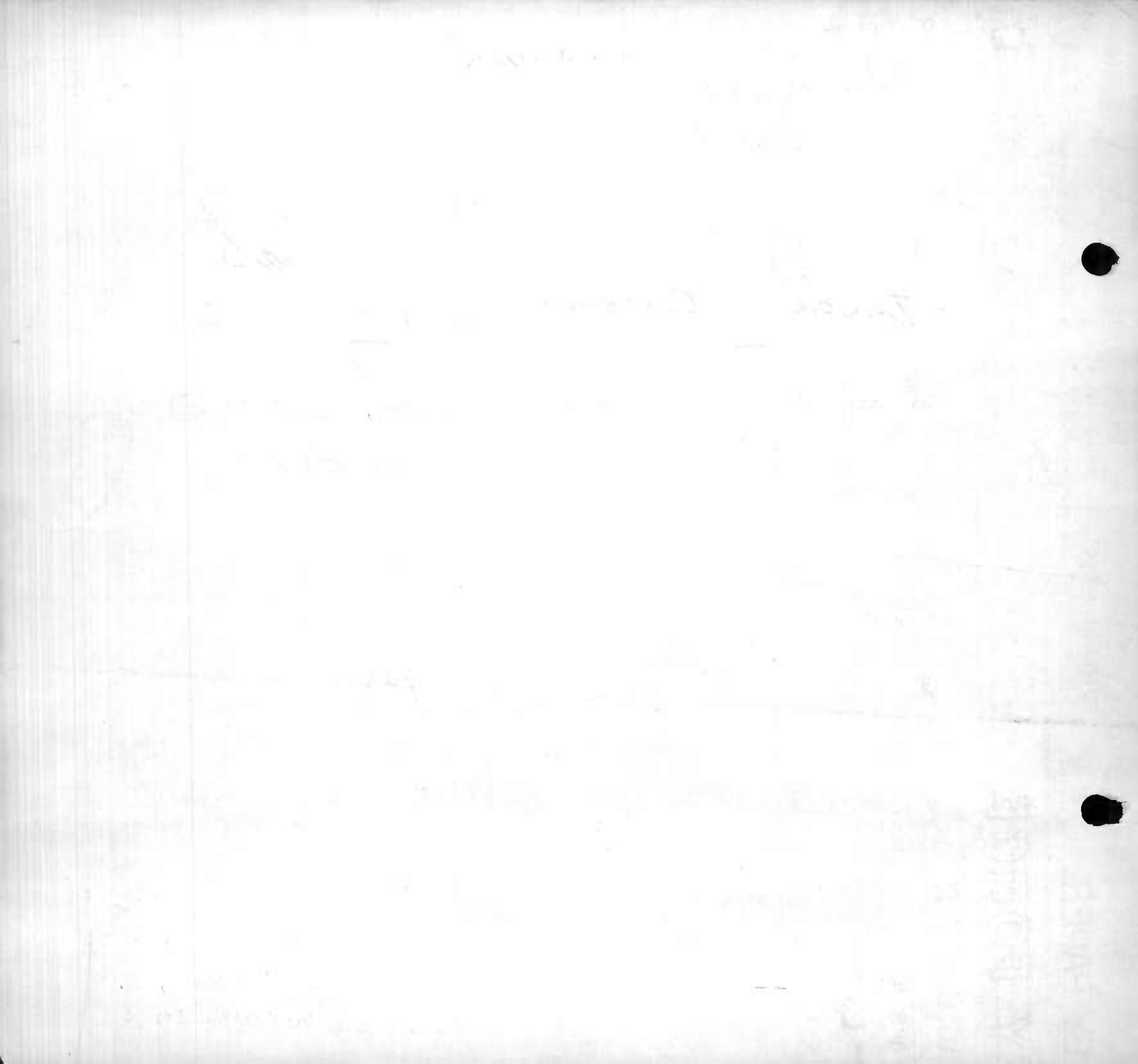
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68- 4768</span>
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		BEULAH J. WARNICK		MAY 4, 1968 <span style="float: right;">330 P. M.</span>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  38 UNIVERSITY HOSPITAL			A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY	
			C. CITY OR TOWN Baltimore	
			D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER 1328 Washington Blvd.	
5. SEX FEMALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1889	9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Frostburg, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Barney Wilson			14. MOTHER'S MAIDEN NAME Martha Wilson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 218-26-8344	17. INFORMANT Mrs. Betty Nolan, 1328 Washington Blvd.
18. <span style="font-size: 1.5em;">404X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH  <i>acute Cardiac Failure</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiovascular Renal Disease</i> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.5em;">442X II</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>  <i>10 yrs</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/8/59</i> 19 <i>574</i> to <i>574</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>574</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Joseph G. Launaitis</i>			23B. DATE SIGNED <i>5/5/68</i>	
23C. PHYSICIAN'S NAME (Type) JOSEPH G. LAUNAITIS			23D. ADDRESS 679 WASHINGTON BLVD. <i>Baltimore 30 MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5-8-1968	24C. NAME of CEMETERY or CREMATORY Frostburg Mem. Park Cem.	24D. LOCATION (City, town, or county) (State) Frostburg, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1968	25B. NAME OF REGISTRAR <i>Robert E. Fairburn</i>	25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

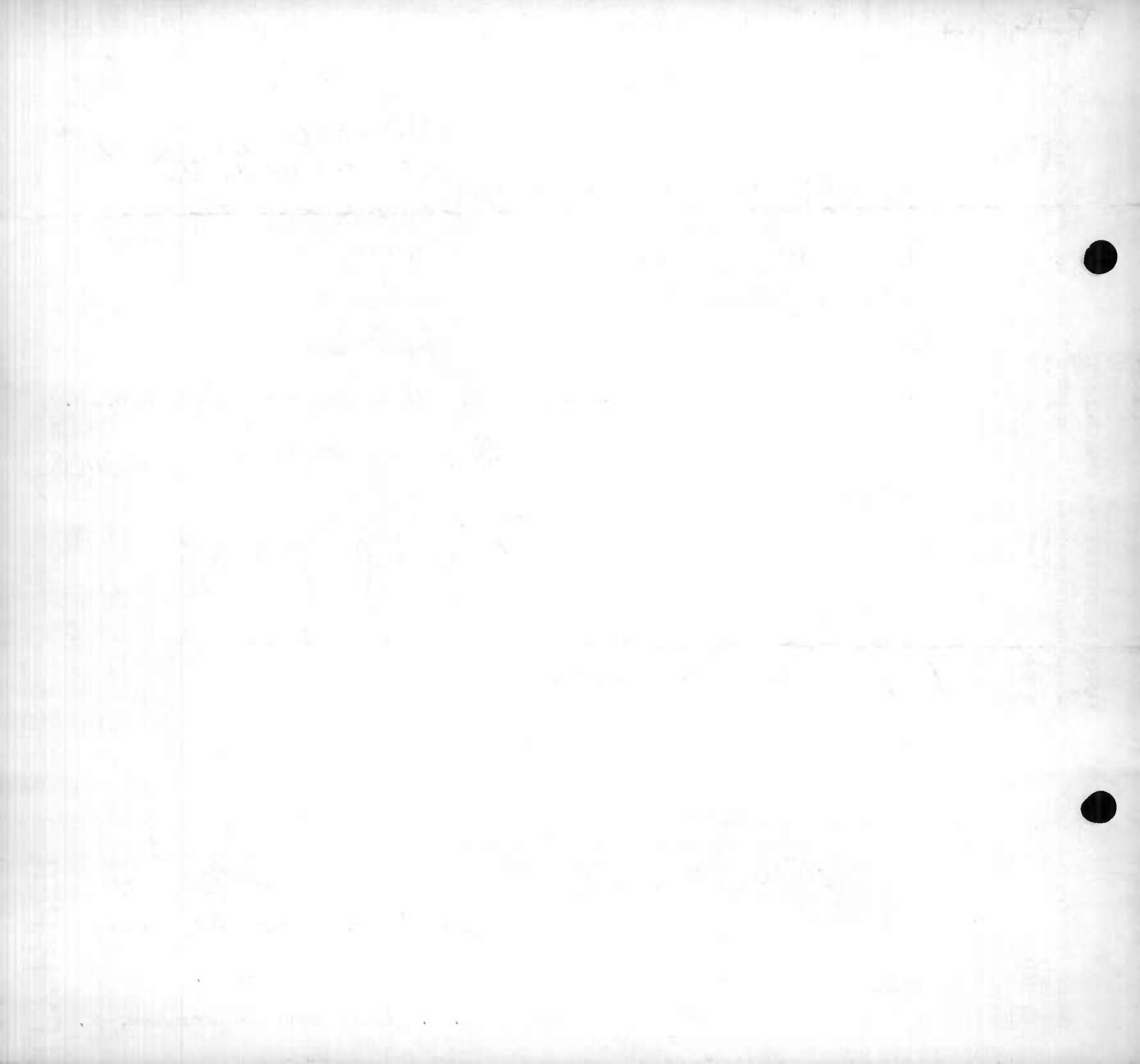
BIRTH NO. <b>M-452</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>68-4769</b>	
<b>CERTIFICATE OF DEATH</b>					
<b>M.E. CASE NO.</b> <b>BRONISLAW MALINAUSKAS</b>					
<b>1. NAME OF DECEASED</b> <b>Malinauskas Bronislaw</b>					
<b>2. DATE AND HOUR OF DEATH</b> <b>3 May 68 8:00 P.M.</b>					
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>					
<b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <b>38 Univ Md Hosp</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>MD</b> <b>B. COUNTY</b> <b>Baltimore</b>		
<b>5. SEX</b> <b>M</b>			<b>6. RACE</b> <b>W</b>		
<b>7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)</b> <b>W</b>			<b>8. DATE OF BIRTH</b> <b>5-4-17</b>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>CLOTHING</b>		
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Waterbury Conn</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b>			<b>14. MOTHER'S MAIDEN NAME</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>#2 WW</b>			<b>16. SOCIAL SECURITY NO.</b> <b>010-14-0546</b>		
<b>17. INFORMANT</b> <b>Thomas Gray, 3 E Lexington St Balto Md</b>			<b>ADDRESS</b>		
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>Bronchial Thrombosis</b>					
<b>ANTECEDENT CAUSES</b>					
<b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b> <b>5/2/68</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>YES</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 5/2/68 19 to 5/3/68 19 that (I) (we) last saw the deceased alive on 5/3/68 19 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>John W. Elkhart</b>				<b>23B. DATE SIGNED</b> <b>3 May 68</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>John W. Elkhart</b>				<b>23D. ADDRESS</b> <b>Univ Md Hosp.</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>5-8-68</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Baltimore National Cem</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 7 1968</b>			
<b>25B. NAME OF REGISTRAR</b> <b>John E. Johnson</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Thomas J. Kerry Inc 1600 Hollins St</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
68-4770		CERTIFICATE OF DEATH		68-4770	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
LOUIS PFAFF			5/2/68 18:20 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence below admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
42 SINAI HOSP. OF BALTIMORE			MARYLAND Baltimore 53-00		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			REISTERSTOWN, MD.		
			D. STREET ADDRESS (If rural, give location)		
			ROUTE 3 Box 127		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
M	W	Widowed	April 7, 1886	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired from Railroad			New York City		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Louis Pfaff			Winfred Fraye		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			579-14-7544		Mr. Clifford Sullivan Reisterstown, Md.
18. 193X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		4 months
194X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Respirical metastatic metastatic Ca of thyroid gland		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
4/29/68			Dysphagia		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Pedro M. Frisch			5/2/68		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
			SINAI HOSP. OF BALTIMORE		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	May 6, 68	Loudon Park Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 7 1968		Robert E. Schuyler		J. F. Eline & Sons Reisterstown, Md.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4771

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO.

68- 4771

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>STANLEY S. BROWN, Sr.</b>		2. DATE AND HOUR OF DEATH <b>5-4-68 2:35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b>				A. STATE <b>MARYLAND</b> B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2904 STRICKLAND ST</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/25/18</b>	9. AGE (In years lost birthday) <b>49</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>S. J. BROWN</b>				12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
14. MOTHER'S MAIDEN NAME <b>Rose WITZ</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO. <b>219-01-6322</b>		17. INFORMANT <b>Mrs. Lillian V. Brown, Balto., Md. 21223</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic cardio vascular disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-2-68</b> to <b>5-4-68</b> , that (I) (we) last saw the deceased alive on <b>5-4-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Fredrick B. Bjornsson</b> DEGREE				23B. DATE SIGNED <b>5-4-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRIDTJOFUR BJORNSSON</b> DEGREE				23D. ADDRESS <b>Maryland General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-8-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Dulaney Valley Memorial Gardens</b>	
24D. LOCATION (City, town, or county) <b>Balto., Md.</b>		24E. ADDRESS <b>4101 Edmondson Avenue</b>		24F. FUNERAL DIRECTOR <b>Witzke Funeral Directors, Balto., Md. 21229</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Witzke Funeral Directors, Balto., Md. 21229</b>	



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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-4772

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN PLITKO		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 4, 1968 4:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 Yard of 400 E. Lexington Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year May 4, 1968 4:45 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH April 10, 1910		10. AGE (In years last birthday) 58	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Erika Plitko, Balto., Md. 21202		ADDRESS 146 North Gay Street	
19. E 962.10 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carbon Monoxide Poisoning (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
E 973.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Yard (car)	
22D. TIME OF INJURY (APPROX.) May 4, 1968 3:55 a.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Yard of 400 E. Lexington Street		22F. HOW DID INJURY OCCUR? Carbon monoxide poisoning	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 5-4-68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-7-68	
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1968		25B. NAME OF REGISTRAR R. E. F. J. J. J.	
25C. FUNERAL DIRECTOR Witzke Funeral Directors, Balto., Md. 21229		ADDRESS 4101 Edmondson Avenue	

Geo. W. Marshall

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">P-362</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">68-4773</span>
1. NAME OF DECEASED (Type or Print) <u>Wilbur T. Patrick Sr.</u>		2. DATE AND HOUR OF DEATH <u>5-2-68 5/3/68 17:50 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Chestertown</u> INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>117 S. College Avenue</u>		
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-11</u>	9. AGE (In years last birthday) <u>56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Light/Power Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>McKendree Patrick</u>		
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>212-10-0693</u>		17. INFORMANT <u>Son</u> ADDRESS <u>Thomas Patrick Chestertown, Md.</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, apoplexy, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Gastro-intestinal bleeding - ulcer.</u> 16 hr.		
(C) _____		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A) <u>Arteriosclerotic Cardio-vascular disease</u>		
19A. DATE OF OPERATION <u>5-2-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>UGI Bleed</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (mostly medical examiners) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME OF INJURY (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____
22. I certify that (I) (this hospital) attended the deceased from <u>4-13-68</u> 19 to <u>5-3-68</u> 19, that (I) (we) last saw the deceased alive on <u>5-3-68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>James F. Sirodano</u>		23B. DATE SIGNED <u>5-3-68</u>		23C. PHYSICIAN'S NAME (Type) <u>JAMES F. SIRODANO</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/8/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>
24D. LOCATION (City, town, or county) <u>Chestertown, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>J. Wells Wells</u> ADDRESS <u>Chestertown, Md.</u>		

2000 10 10

Harvard University

Cambridge

117 2 College Avenue

12-11-11 26

Harvard

Unknown

Harvard General Hospital

Male

Left/Right

Former

Matthew Police

2000-10-10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4774

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4774

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Paul W. Shaffer

2. DATE AND HOUR OF DEATH

5.2.68

3 30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

38

Baltimore Md

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Md

Inverhick G 60-00

C. CITY OR TOWN

Thurmont

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

219 W. Maine St.

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

10.14.04

9. AGE (In years  
last birthday)

63

11. Under 1 Yr.  
Months: DaysIf Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

unemployed

10B. KIND OF BUSINESS OR INDUSTRY

Unemployed

11. BIRTHPLACE (State or foreign country)

Frederick Co.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Frank E. Shaffer

14. MOTHER'S MAIDEN NAME

Mary Fralay

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

213-18-0637

17. INFORMANT

Hazel D. Shaffer Thurmont, Md.

ADDRESS

## CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Cardiac arrest

(B) *Gastric perforation*  
DUE TO, OR AS A CONSEQUENCE OF:(C) *Aortic Abdominal Aneurysm*OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Cardiac Disease

19A. DATE OF OPERATION

5.1.68

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Gastric bleeding &amp; perforation

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 19  
that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Rogers Pierson M.D.

OEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5.2.68

23C. PHYSICIAN'S  
NAME (Type)

ROGERS PIERSON

OEGREE

23D. ADDRESS

University Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5-5-68

24C. NAME OF CEMETERY or CREMATORY

Blue Ridge Cemetery

24D. LOCATION

Thurmont Fred. Co. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 7 1968

25B. NAME OF REGISTRAR

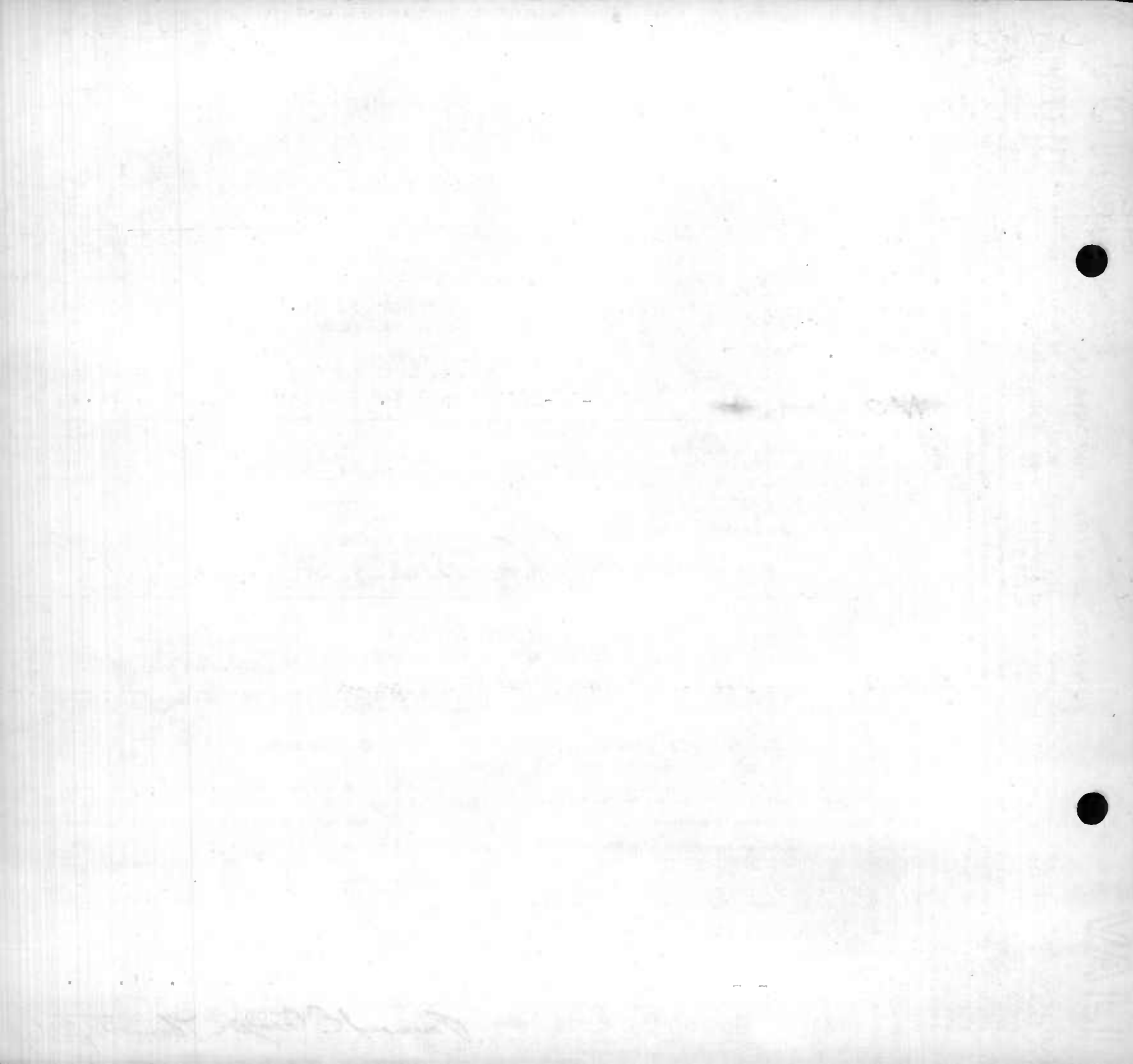
Robert E. Jackson

25C. FUNERAL DIRECTOR

Raymond E. Croager

ADDRESS

Thurmont, Md.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-4775

BIRTH NO.

REG. NO.

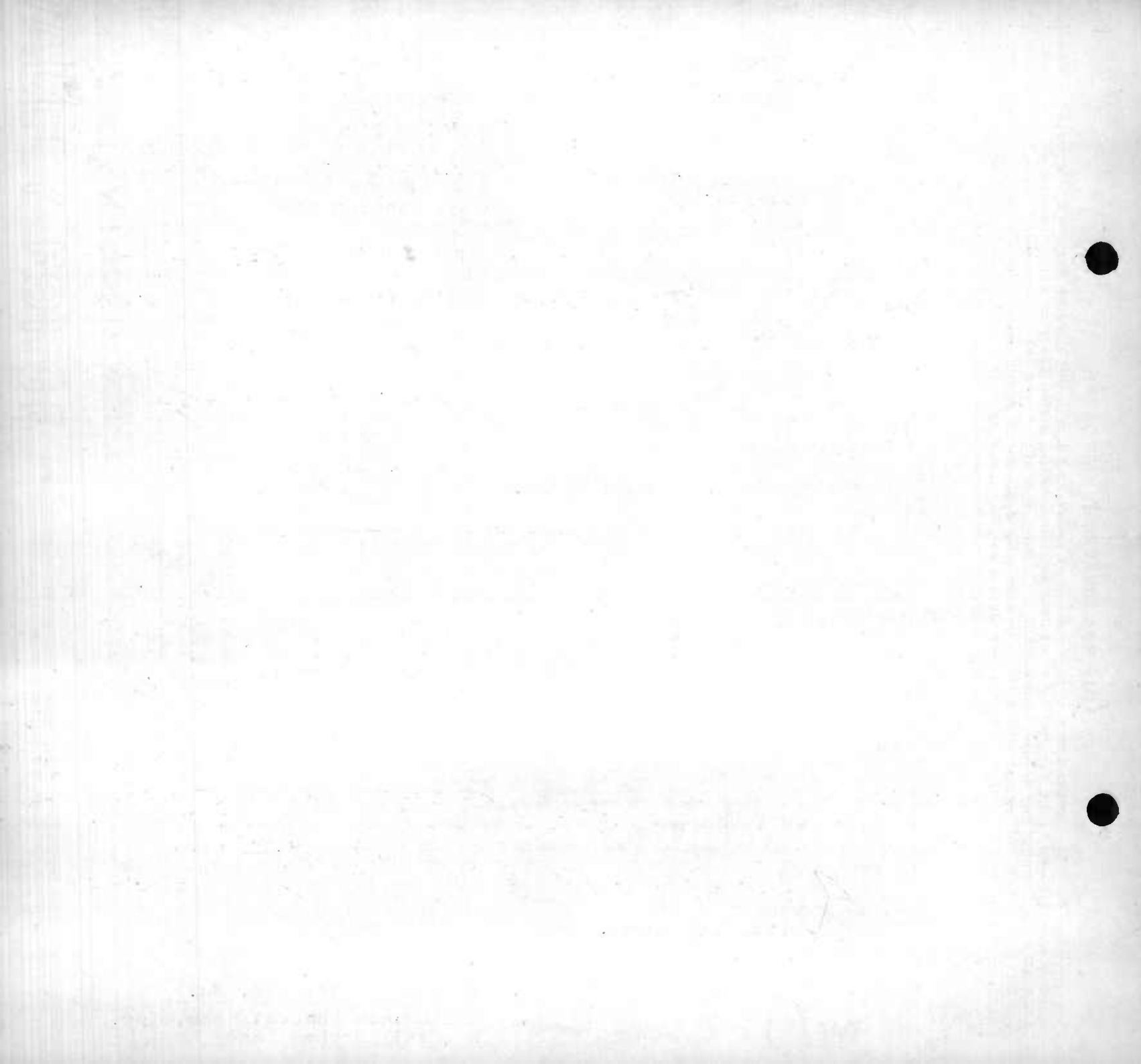
1. NAME OF DECEASED (Type or Print) <b>CHARLES A. JOHNSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 4, 1968</b>		Hour <b>12:08 A</b> M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 3821 Belair Road</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 4, 1968</b>		Hour <b>12:08 A</b> M.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Mayland</b> B. COUNTY				
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>separated</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>11/23/1895</b>		10. AGE (In years lost birthday) <b>72</b>		E. STREET AND NUMBER <b>3821 Belair Road</b>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Johnson</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>John B. Bocks Rest.</b>		15. MOTHER'S MAIDEN NAME <b>unknown</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>222-03-8506</b>		18. INFORMANT <b>Charles H. Johnson, son, above</b>
19. <b>153.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Carcinoma of Colon</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
153.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/7/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>R. O. G. [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>

WALLINGTON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Orem</b> <b>EARL Cusick</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>5-3-68</b>   <b>9<sup>00</sup></b> M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>49 North Charles General Hospital</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) <b>A. STATE</b> <b>Md</b> <b>B. COUNTY</b> <b>Baltimore</b> <b>53-00</b> <b>C. CITY OR TOWN</b> <b>BALTIMORE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>531 Langley Road</b>		
<b>5. SEX</b> <b>M</b>	<b>6. RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9-18-12</b>	<b>9. AGE</b> (In years last birthday) <b>55</b> <b>If Under 1 Yr.</b> Months: <b>-</b> Days: <b>-</b> <b>If Under 24 Hrs.</b> Hours: <b>-</b> Min: <b>-</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Bethlehem Steel</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA.</b>		<b>13. FATHER'S NAME</b> <b>William Cusick</b>		
<b>14. MOTHER'S MAIDEN NAME</b> <b>Vera Phillips</b>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) <b>-</b> <b>16. SOCIAL SECURITY NO.</b> <b>214-07-9403</b>		
<b>17. INFORMANT</b> <b>Chart N. Ch. G. Hosp.</b>		<b>ADDRESS</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>162.1 I</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Bronchopneumonia</b> <b>Terminal CA of the lungs.</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF:		
<b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>(C)</b> DUE TO, OR AS A CONSEQUENCE OF:		
<b>163X II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <b>2</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>yes</b>
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>yes</b>		<b>21. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b>
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>4-22-1968</b> <b>to</b> <b>5-3-1968</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>5-3-1968</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> <b>9<sup>45</sup> am.</b>				
<b>23A. SIGNATURE</b> <b>Lewis Ryzel</b>		<b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>		<b>23B. DATE SIGNED</b> <b>5-3-68</b>
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>Lewis Kolodny</b>		<b>23D. ADDRESS</b>		
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>5/6/68</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Bel Air Mem. Gardens</b>
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Bel Air, Md.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 7 1968</b>		
<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 4777</b>
BIRTH NO.		68- 4777 <b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
<b>HICKMAN, Richard Emerson</b>		<b>5 MAY 1968</b>		<b>12:10A</b> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
		A. STATE B. COUNTY		
		<b>MARYLAND BALTIMORE CITY</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN D. INSIDE CITY LIMITS?		
<b>VETERANS ADMINISTRATION HOSPITAL</b>		<b>BALTIMORE</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>23 3900 LOCH RAVEN BOULEVARD</b>		E. STREET AND NUMBER		
<b>BALTIMORE, MARYLAND 21218</b>		<b>1507 NORTHGATE ROAD</b>		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
<b>MALE</b>	<b>CAUCASION</b>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>11-24-05</b>	<b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
<b>PLASTERER</b>		<b>CONSTRUCTION</b>		<b>BALTIMORE, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY?		<b>U. S. A.</b>		
13. FATHER'S NAME		MOTHER'S MAIDEN NAME		
<b>HARRY S. HICKMAN</b>		<b>FANNIE SUE RANNEY WHITE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
<b>YES</b>		<b>8-24-43 TO 10-23-45 213-01-5002</b>		<b>V A HOSPITAL RECORDS</b>
				ADDRESS
				<b>3900 LOCH RAVEN BLVD, BALTIMORE, MARYLAND</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
<b>491X + V53.8</b>				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		<b>Severe Pulmonary Insufficiency Years</b>		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>Emphysema and Chronic Bronchitis</b>		
		(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<b>502.0 II</b>				
<b>Carcinoma Colon Resected.</b>				
<b>Polyarthrititis Nodosa, Suspected.</b>				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<b>D</b>		<b>No</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (A) (this hospital) attended the deceased from <b>26 JANUARY</b> 19 <b>68</b> to <b>5 MAY</b> 19 <b>68</b> , that (B) (we) last saw the deceased alive on <b>5 MAY</b> 19 <b>68</b> and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
				
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
<b>VICTOR V. J. BORGES M.D.</b>		<b>3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>	<b>5/8/68</b>	<b>Moreland Memorial Park</b>	<b>Baltimore, Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		
<b>MAY 1 1968</b>	<b>Robert E. Taylor</b>	<b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 4778</u>
<div style="display: flex; justify-content: space-between;"> <span>C-56</span> <span>68- 4778</span> <span>CERTIFICATE OF DEATH</span> </div>				
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <b>SOPHIA MARY CONRAD</b>			2. DATE AND HOUR OF DEATH <b>May 4, 1968</b> <b>12:25 p.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>3583 Shannon Drive</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md. 21213</b> B. COUNTY <b>26-03</b>	
5. SEX <b>female</b> 6. RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>4/21/1891</b> 9. AGE (In years last birthday) <b>77</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assembly (Packer)</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Helwig &amp; Leitch</b>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank Conrad</b>			14. MOTHER'S MAIDEN NAME <b>Josephine Mika</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>214-12-8633A</b>	
17. INFORMANT <b>Mary J. Conrad, sister-in-law, above</b>			ADDRESS	
18. <b>188X I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Generalized Metastasis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma Bladder</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)..... APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b> <b>Nov. 1967</b>				
18. <b>181.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				
MEDICAL CERTIFICATION				
19A. DATE OF OPERATION <b>Nov. 1967</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca - Bladder</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>May 1967</b> to <b>May 4 1968</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>May 3 1968</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>diagnose</del> ) view the body after death.				
23A. SIGNATURE <b>Dr. Louis F. Klimes</b>			23B. DATE SIGNED <b>5/6/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Louis F. Klimes</b>			23D. ADDRESS <b>4814 Bowleys Lane</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/7/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. (State)		
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>
25D. ADDRESS <b>3331 Brehms Lane</b>				

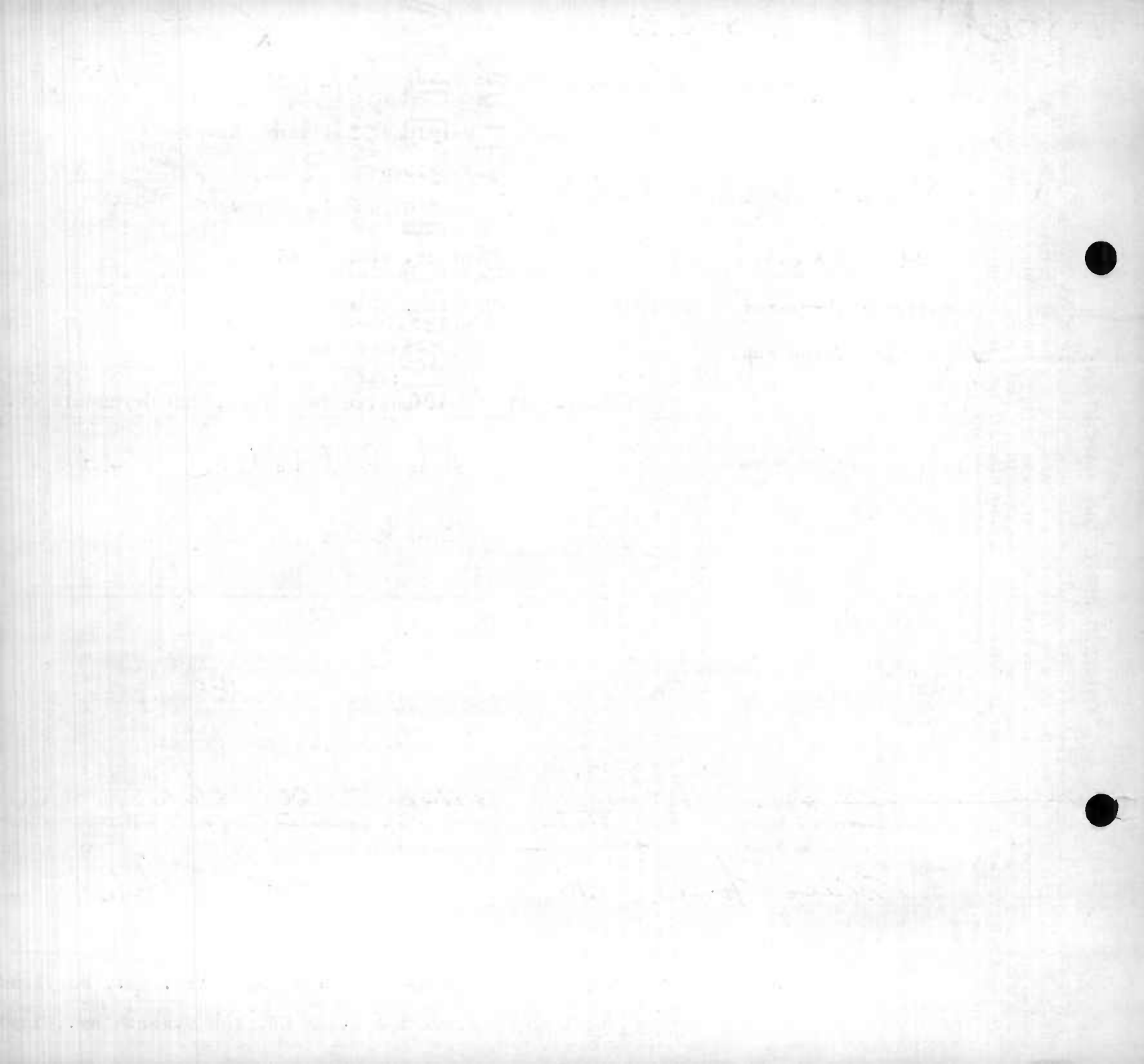




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68-4779</span>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Tang George (GEORGE TANG)</b>		2. DATE AND HOUR OF DEATH <b>5/6/68</b> <span style="float: right;">155 P.M.</span>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>425 W. Hospital of Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore County</b> C. CITY OR TOWN <b>Woodlawn</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>5220 Gwynndale Avenue</b>		
5. SEX <b>M</b>	6. RACE <b>Oriental</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 26, 1901</b>	9. AGE (In years lost birthday) <b>67</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired/Management</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Canton, China</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Tang Chong Wah</b>		
14. MOTHER'S MAIDEN NAME <b>Shee Soo Hoo</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>120-01-4517A</b>		17. INFORMANT: <b>wife</b> ADDRESS <b>21207 Mrs. Annette Wong Tang, 5220 Gwynndale Av.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>5-71.9-1-200.9</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute renal failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>381.0 II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes</b>		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>2</b>		19A. DATE OF OPERATION <b>5/2/68</b>		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY: (Yes or No) <input checked="" type="checkbox"/> <b>No</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>5/2/68</b> 19 <b>68</b> to <b>5/6/68</b> 19 <b>68</b> , that (I) <del>was</del> last saw the deceased alive on <b>5/6/68</b> 19 <b>68</b> and that <del>last</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (We) (did) <del>(did not)</del> view the body after death.				
23A. SIGNATURE <b>Marion Jones MD</b>		23B. DATE SIGNED <b>5/6/68</b>		23C. PHYSICIAN'S NAME (Type) <b>MD</b>
23D. ADDRESS <b>STEWART &amp; MOWEN CO. 108 W. North Av., City</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		
24B. DATE <b>5/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Balto. Co., Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>		25C. FUNERAL DIRECTOR ADDRESS <b>STEWART &amp; MOWEN CO. 108 W. North Av., City</b>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4780	
68-4780				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ARK DONG Wong</b>		2. DATE AND HOUR OF DEATH <b>May 5, 1968 3:00 p.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>12</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>Chinese</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7-1-94</b>		9. AGE (In years last birthday) <b>73</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED COOK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>China</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>X BOK DAN WONG (Dec'd.)</b>		14. MOTHER'S MAIDEN NAME <b>X WOO MAR (Dec'd.)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-46-7499A</b>		17. INFORMANT <b>2428 N. Charles Balot. 108 ARK FUEY WONG (Brother)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ADENOCARCINOMA OF RECTUM &amp; MULTIPLE METASTASES TO KIDNEY, LIVER, &amp; BRAIN.</b>		CAUSE OF DEATH <b>ADENOCARCINOMA OF RECTUM &amp; MULTIPLE METASTASES</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 yrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>15-4X II GASTRIC ULCER.</b>		19A. DATE OF OPERATION <b>1967</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF RECTUM</b>	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-17-1968</b> to <b>5-5-1968</b> , that (I) (we) last saw the deceased alive on <b>5-5-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ira L. Fetterhoff M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5 May 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>IRA L. FETTERHOFF M.D.</b>		23D. ADDRESS <b>1213 LIGHT ST</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/7/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>	
24D. LOCATION <b>Woodlawn, Balto. Co., Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Stewart &amp; Mowen Co.</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>108 W. North Av. Cityl</b>					

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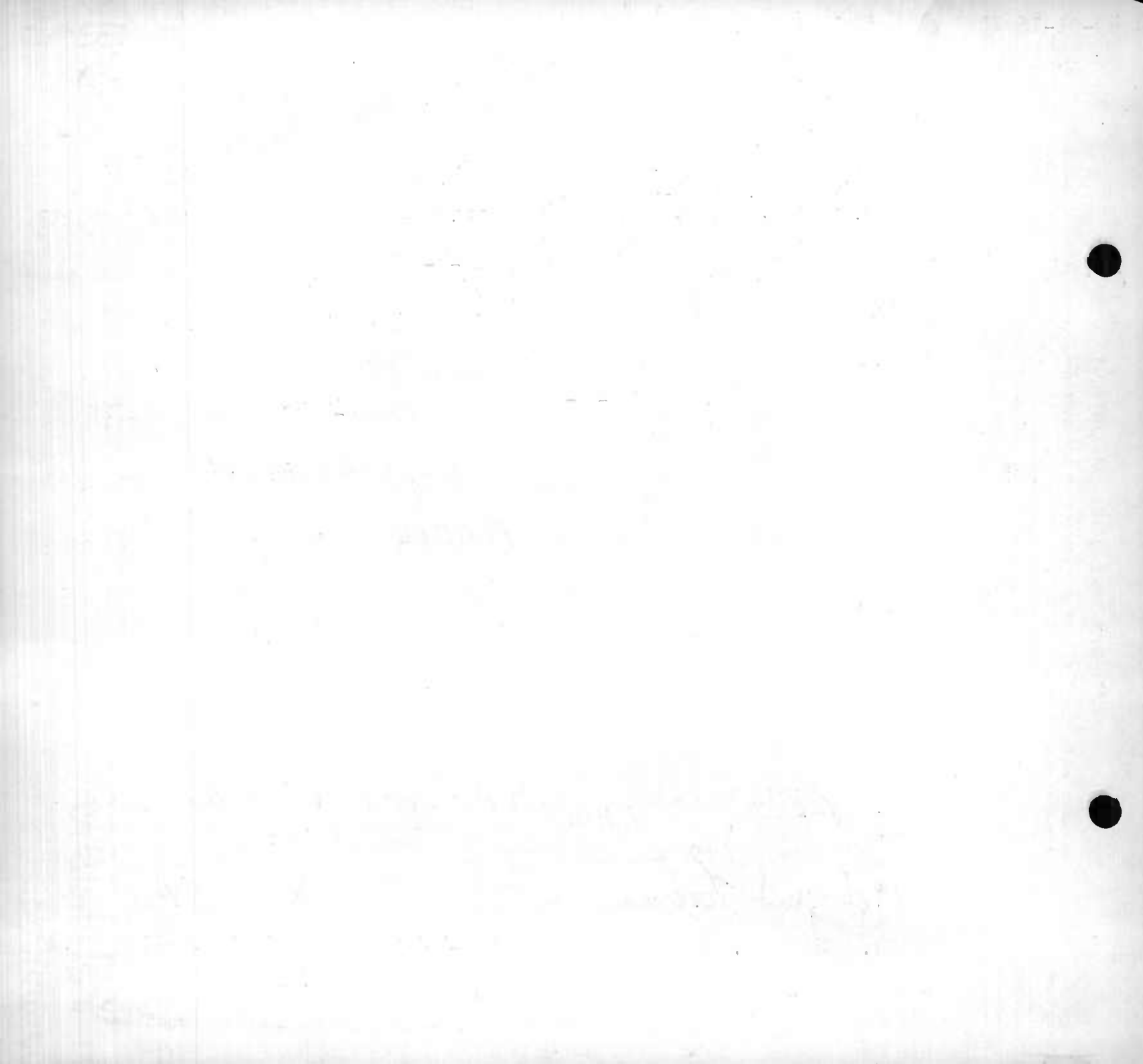
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-4781

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EARL MOORE</b>		2. DATE AND HOUR OF DEATH <b>May 4, 1968</b> <b>5<sup>05</sup> A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>		E. STREET AND NUMBER <b>1339 PATTERSON PARK AVENUE #21213</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-4-05</b>	9. AGE (in years lost birthday) <b>62</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WASHINGTON JONES</b>		14. MOTHER'S MAIDEN NAME <b>WATKINS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-05-9890</b>		17. INFORMANT <b>RECORDS-BCH-4940 EASTERN AVENUE</b>	
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Arrest</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Multiple CVA's</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>331X II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Positive CSF Serology</b>		3 yr.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9 AUGUST 1967</b> to <b>4 MAY 1968</b> , that (I) (we) last saw the deceased alive on <b>4 MAY 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Melvyn S. Tockman</b>		23B. DATE SIGNED <b>4 May 1968</b>			
23C. PHYSICIAN'S NAME (Type) <b>DR. MELVYN S. TOCKMAN</b>		23D. ADDRESS <b>BCH-4940 EASTERN AVENUE, BALTIMORE, MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/9/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetry</b>	
24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Ave</b>		25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

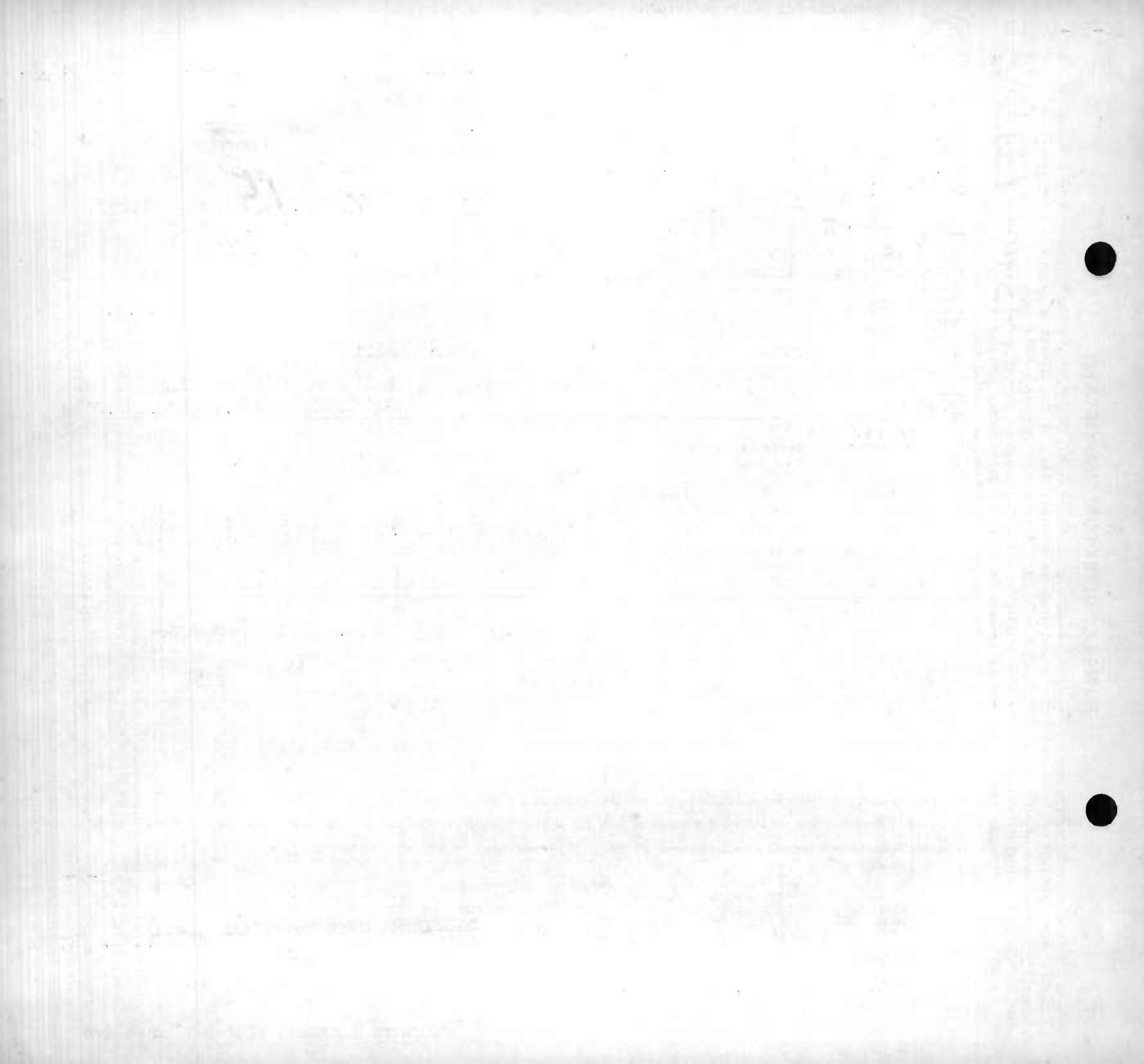




BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PURDY HARVIN PURDY HARVIN</b>		2. DATE AND HOUR OF DEATH <b>MAY 3, 1968 11:11 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE MARYLAND #21224</b>			C. CITY OR TOWN <b>BALTIMORE</b> IDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
5. SEX <b>Male</b> 6. RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			E. STREET AND NUMBER <b>2254 Madison Ave. 21217</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINE</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Br own Harvin</b>			14. MOTHER'S MAIDEN NAME <b>Lizzie Smilin</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>RECORDS: BALTIMORE CITY HOSPITALS</b> ADDRESS <b>4940 EASTERN AVE., BALTO., MD. 21224</b>					
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>PULMONAR EDEMA</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PULMONAR EDEMA</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>ARTERIOSCLEROTIC HEART DISEASE</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROTIC HEART DISEASE</b>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>PERINEAL TRANSITIONAL CELL CARCINOMA</b>			(C) DUE TO, OR AS A CONSEQUENCE OF: <b>PERINEAL TRANSITIONAL CELL CARCINOMA</b>		
19A. DATE OF OPERATION <b>April 3, 1968</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Periurethral abscess</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 26</b> 19 <b>68</b> to <b>MAY 3</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>MAY 3</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ovidio Vitas MD</b> DEGREE				23B. DATE SIGNED <b>May 3, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ovidio E. Vitas MD</b> DEGREE				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. #21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/9/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetry</b>	
24D. LOCATION (City, town, or county) <b>A A County Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Ave</b>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



B-254

68-4783

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-4783

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN BOZEMORE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 5, 1968</b> Hour: <b>3:45 A.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>PROVIDENT HOSPITAL (DOA)</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year <b>May 5, 1968</b> Hour: <b>3:45 A.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10/31/43</b>		10. AGE (In years lost birthday) <b>24</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mover</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs Bessie Bazemore</b>		ADDRESS <b>same</b>	
19. CAUSE OF DEATH <b>E965X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of Aorta</b> ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>E981X</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Lafayette and Pennsylvania Avenue</b>		22F. HOW DID INJURY OCCUR? <b>Shot by unknown assault</b>	
22D. TIME OF INJURY (APPROX.) May 5, 1968 3:25 a.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type): <b>Edward F. Wilson, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: <b>5-5-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/8/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Adolphus Halstead 1206 W North Ave</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Halstead</b>	
25C. FUNERAL DIRECTOR <b>A. HALSTEAD</b>		ADDRESS	

WALLACE HOPPE

22/11/1975

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-4784		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4784	
1. NAME OF DECEASED (Type or Print) <b>JOSAPHINE BARNES</b>			2. DATE AND HOUR OF DEATH <b>5/5/68 5:45 p.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 LUTHERAN HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1501, DUKELAND ST.</b>		
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>89</b>	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Fun. clark.</b> ADDRESS	
18. <b>25010 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Diabetic Coma.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>—</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>—</b>		
18. <b>260X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<b>Pneumonia.</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/1/1968</b> to <b>5/5/1968</b> , that (I) (we) last saw the deceased alive on <b>5/5/1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>5/5/68.</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAVID KROD</b>				23D. ADDRESS <b>LUTHERAN HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b> ADDRESS <b>1206 W North Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-632		68- 4785		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 4785	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Charles A Pertsch</b>			
2. DATE AND HOUR OF DEATH <b>5/6/68 9:50 PM</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY				5. SEX <b>M</b> 6. RACE <b>W</b>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>5/3/1898</b>			
9. AGE (In years lost birthday) <b>70</b>				10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Senior Dist. Supervisor B. City Schools</b>			
11. BIRTHPLACE (State or foreign country) <b>Balto- Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John George Pertsch</b>				14. MOTHER'S MAIDEN NAME <b>ANNA DANZER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.1</b>				16. SOCIAL SECURITY NO. <b>220-22-2431</b>			
17. INFORMANT <b>John J. Pertsch 112 Hollow Brook Rd.</b>				18. 4-12-3-1-199-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Bronchopneumonia, Atrial Fibrillation</b>			
19. 433.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				20. A. IMMEDIATE CAUSE <b>Metastatic Ca to lungs, liver &amp; spleen</b>			
21. B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				22. C. DUE TO, OR AS A CONSEQUENCE OF: <b>A.S.C.V.D.</b>			
23. D. DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic Ca to lungs, liver &amp; spleen</b>				24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>5/2/68</b> to <b>5/6/68</b> 19		that (I) (we) last saw the deceased alive on <b>5/6/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Abdelhamid Ghiladi</b>				23B. DATE SIGNED <b>5/6/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Abdelhamid Ghiladi</b>	
23D. ADDRESS <b>Mercy Hospital</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/9/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>				24D. LOCATION (City, town, or county) (State) <b>Balto. d.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>				25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>		25D. ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-462		68-4786		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4786	
1. NAME OF DECEASED (Type or Print) <b>Bertie Clarke</b>				2. DATE AND HOUR OF DEATH <b>May 5, 1968</b> <span style="float: right;"><b>8:30 P.</b></span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY  C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>5-03</b> E. STREET AND NUMBER <b>1810 N. Bentalou Street</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1906</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		
13. FATHER'S NAME <b>John Howard</b>			14. MOTHER'S MAIDEN NAME <b>Lillie Denson</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>214-40-5264</b>		17. INFORMANT ADDRESS <b>Mr. Torrey Clarke 1810 N. Bentalou Street</b>		
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenea, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <b>H.C.V.D.; A.S.H.D.</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Bronchitis &amp; Emphysema</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>"</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>502.0 II</b>							
19A. DATE OF OPERATION <b>0 N/A</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>N/A</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>N/A</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, lactory, street, office bldg., etc.) <b>N/A</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>N/A</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>N/A</b>		21E. INJURY OCCURRED White At <input type="checkbox"/> <b>N/A</b> Not White At <input type="checkbox"/> <b>N/A</b>		21F. HOW DID INJURY OCCUR? <b>N/A</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>5-13-1968</b> to <b>5-13-1968</b> that (I) (we) last saw the deceased alive on <b>5-13-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>U. RAY JR</b>				23B. DATE SIGNED <b>5/7/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>U. RAY JR M.D.</b>				23D. ADDRESS <b>2225 W North Ave Baltimore 21216</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-8-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>5501 Fred'k Ave. Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Joseph L. Russ</b>			
ADDRESS <b>2222 W. North Ave, Baltimore, Maryland</b>							

H. V. D. F. 28. D.

General Investigation

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M.D.

M.D.

5557 W. 11th St. S.

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B-400 68-4787 BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-4787

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>CHARLES BELL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 26, 1968</b> <b>11:00 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2233 Mt. Holly Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 26, 1968</b> <b>11:00 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>May 18, 1918</b>		10. AGE (In years last birthday) <b>49</b> 50?	
11. BIRTH PLACE (State or foreign country) <b>Clonville, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Bell, Sr.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Kate Bell</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Hampton James Van Hampton, Va.</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15-09</b>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>422.1 II</b>			
22A. DATE OF OPERATION <b>2</b>		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>	
25. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4-26-68</b>	
26. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
27. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 7, 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Leafield Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Hampton, Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Ruben E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>Joseph A. Russ</b>		25D. ADDRESS <b>2202 W. North Ave., Baltimore, Md.</b>	

VS 151-REV. 1/1/68

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T-545 68-4788 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-4788

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month		Day		Year		Hour	
		LEROY THOMLIN <i>Tomlin</i>		5		5		68		10:00		am.	
33 99		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD		Month		Day		Year		Hour	
		Johns Hopkins Hospital D.O.A.		May		5		1968		10:00		am.	
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?					
Male		Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
9. DATE OF BIRTH		10. AGE (In years last birthday)		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER							
11-28-39		28				3112 E. Biddle St.							
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME									
Sumter, S.C.		U.S.A.		Robert Tomlin									
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME									
Welder		Shipyard		Marie Seymore									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS							
				Mary Tomlin, Sumter, S.C.									
19. 493X I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:											
(C) DUE TO, OR AS A CONSEQUENCE OF:													
241X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)									
2				YES									
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?									
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?									
23.													
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)							
Removal		5-8-68		Mulberry Cemetery		Sumter, S.C.							
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS							
MAY 7 1968		Robert E. Fairbank		Randolph J. Collick		2431 E. Oliver St.							

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11-22-22

Robert Tenlin

W.S.B.

Sumner, S.C.

Marie Seymour

Shipyard

Weider

Mary Tenlin, Sumner, S.C.

WALTER FOR

150-100000

Sumner, S.C.

Removal 2-8-22 Antwerp, S.C.

Robert Tenlin



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-140		68- 4789		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68- 4789	
BIRTH NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <b>De Palo Mrs MARY</b>					3rd May 1968 9-05 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 CHURCH HOME AND HOSPITAL</b>					A. STATE <b>MARYLAND</b> B. COUNTY				
					C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>3-02</b>		
					E. STREET AND NUMBER <b>117 S. CENTRAL AV</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-29-08</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STITCHER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>SHOES.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>XAVIER JEANNETTE</b>					14. MOTHER'S MAIDEN NAME <b>FANNY RIZZO</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>/</b>			16. SOCIAL SECURITY NO. <b>214-24-7686</b>		17. INFORMANT ADDRESS <b>4445 RASPE AVE</b> <b>Mrs ROSE ELLE GROWSKOWSKI</b>				
18. I <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Canceroma Cervix, Terminal</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>171X II</b>									
19A. DATE OF OPERATION <b>4-3-1968</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Epigastric Pain</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (N) (this hospital) attended the deceased from <b>3-31-1968</b> to <b>5-3-1968</b> , that (N) (we) last saw the deceased alive on <b>5-3-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Josey. Ortiz</b> OEGREE					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>5/3/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSE ORTIZ</b> DEGREE					23D. ADDRESS <b>CHURCH HOME &amp; HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/6/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>GARDENS OF FAITH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>			25C. FUNERAL DIRECTOR <b>Frank Della Voce</b>			ADDRESS <b>322 N. High St.</b>	

JOSE OTIS  
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No

CHURCH BOOKS

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>68-4790</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>68-4790</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>Shepley Hopkins</b>			2. DATE AND HOUR OF DEATH <b>5/3/68</b> <b>3 A</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL</b> C. CITY OR TOWN <b>ANNAPOLIS</b> (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <b>8 MARYLAND AVE.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>			FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NM</b>	8. DATE OF BIRTH <b>1/9/67</b>	9. AGE (In years last birthday) <b>1</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NA</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>George Hopkins</b>			14. MOTHER'S MAIDEN NAME <b>ANNE FLYNN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>George E Hopkins - Annapolis, Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>192.9 I</b> <b>Hyperkalemia + Hypoxemia</b>			CAUSE OF DEATH (A) <b>Hyperkalemia + Hypoxemia</b> DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>METASTATIC NEUROBLASTOMA</b> DUE TO		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>193.9 II</b>			(C)		
19A. DATE OF OPERATION <b>3/8, 4/25, 5/1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NEUROBLASTOMA</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NA</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NA</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NA</b>	
21D. TIME OF INJURY (APPROX.) <b>NA</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> <b>NA</b> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>NA</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>3/4</b> 19 <b>68</b> to <b>5/3</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5/3</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>F. J. Scarpa</b>				23B. DATE SIGNED <b>5/3/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRANCIS J. SCARPA</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Mary's Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Annapolis MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>			
25B. NAME OF REGISTRAR <b>R. E. E. F. F.</b>		25C. FUNERAL DIRECTOR <b>George E. Hopkins</b>			
25D. ADDRESS <b>Hopping Funeral Home - Annapolis, Md.</b>					

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
SCOTT R. ANDERSON		5-3-68 1 PM		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		MARYLAND HOWARD		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
3 THE JOHNS HOPKINS HOSPITAL		COLUMBIA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER		10 474 GRAY OWL GARTH		5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
MALE WHITE		8-31-59		8. DATE OF BIRTH 9. AGE (In years last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
STUDENT		NONE		11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?	
MASS					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
RICHARD L. ANDERSON		JUNE PERKETT		No	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NONE		Richard L. Anderson		Columbia, Md.	
		10474 Gray Owl GARTH		21043	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Cyanotic congenital heart disease			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Status post-op aorto-pulmonary shunt		18hrs	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
3 5/12/68		Cyanosis and heart failure		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				No	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 1 1968 to May 3 1968, that (I) (we) last saw the deceased alive on May 3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
R. L. Hurwitz M.D.		5/13/68		Richard L. Hurwitz	
23D. ADDRESS		23E. NAME OF CEMETERY or CREMATORY		23F. LOCATION (City, town, or county) (State)	
Johns Hopkins Hospital		W. Nottingham Cem.		W. Nottingham Cecil Co Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5-6-68		W. Nottingham Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 7 1968		R. L. Hurwitz		John R. Shook	
				E. Elliott City Md.	



FUNERAL DIRECTOR: IMPORTANT

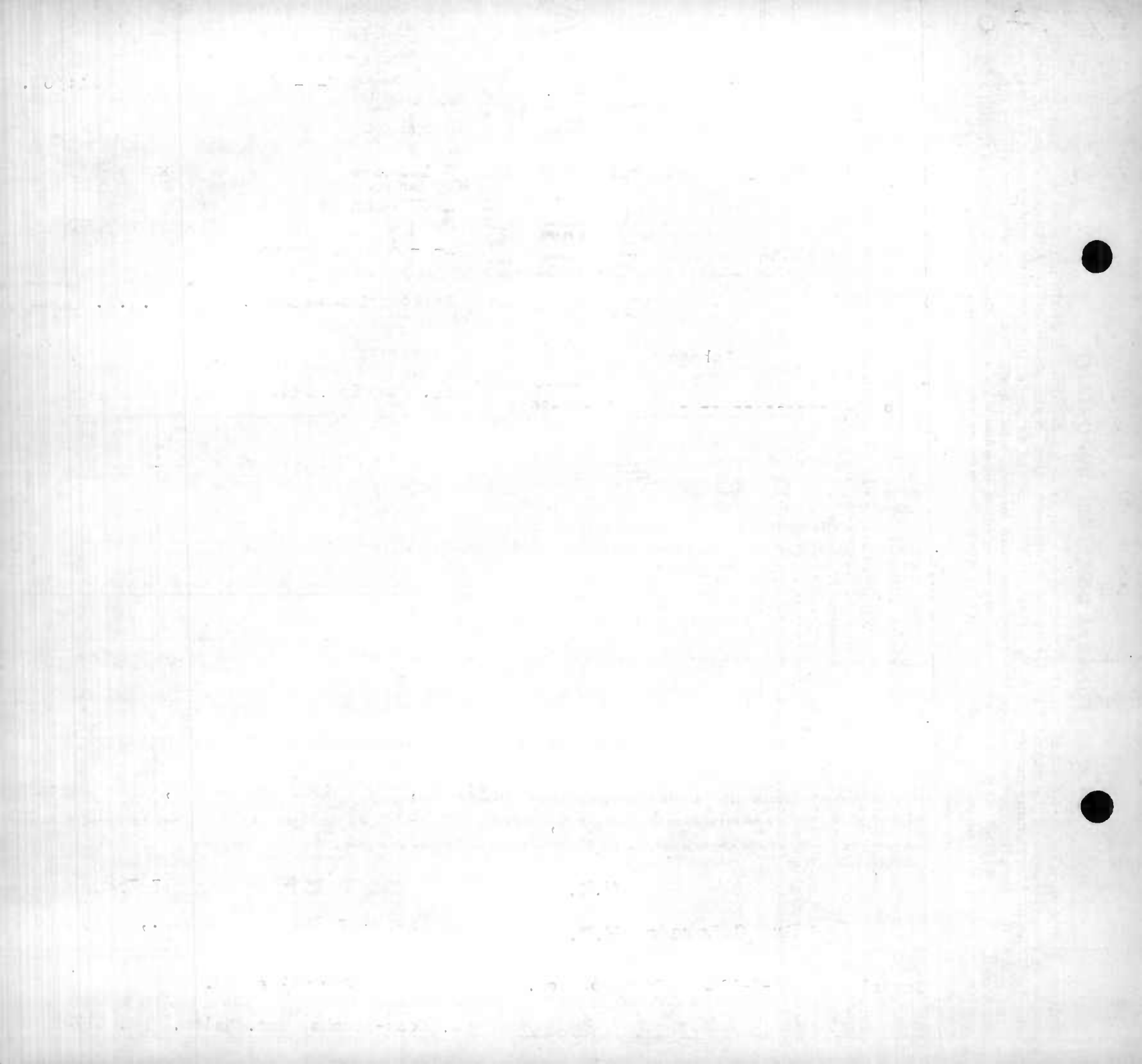
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 4792 CERTIFICATE OF DEATH

REG. NO. 68- 4792

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Estella Lutz</b>		2. DATE AND HOUR OF DEATH <b>5-3-68 11:30A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1400 Johns Street</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-84</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>??? Lohman</b>		14. MOTHER'S MAIDEN NAME <b>????????????????</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-5632</b>		17. INFORMANT ADDRESS <b>Mrs. Jennie Romeo</b>	
18. CAUSE OF DEATH <b>427.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>congestive heart failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>34.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 23, 1968</b> to <b>May 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>May 3, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. C. Laredo M.D.</b>				23B. DATE SIGNED <b>5-3-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. C. Laredo M.D.</b>				23D. ADDRESS <b>1514 Division Street Balto., Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-7-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cem.</b>	
24D. LOCATION <b>Parkville, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		24F. NAME OF REGISTRAR <b>R. E. Farber</b>	
24G. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc.</b>		24H. ADDRESS <b>Balto., Md. 21202</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4793
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>407 LOUISE O'CONNOR</b>		2. DATE AND HOUR OF DEATH <b>5/3/68 8:10 A.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>9-05</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSP.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>701 GORSUCH AVENUE</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/22/1883</b>	9. AGE (In years lost birthday) <b>85 27</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>JACOB WITMER</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>244-05-0195</b>		17. INFORMANT <b>CLAXTON O'CONNOR</b>
18. <b>038.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>SEPTICEMIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>35-3.4 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>NO</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) <u>this hospital</u> attended the deceased from <b>April 19 19 68</b> to <b>May 3 19 68</b> , that (I) <u>(we)</u> last saw the deceased alive on <b>May 3 19 68</b> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.				
23A. SIGNATURE <b>Enrique Cipriani M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/3/68</b>
23C. PHYSICIAN'S NAME (Type) <b>ENRIQUE CIPRIANI M.D.</b>		23D. ADDRESS <b>33rd AND CALVERT STs.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5-6-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc.</b>
				ADDRESS <b>1217 St. Paul St. Balt., Md. 21202</b>

Union Memorial Park  
101 GERSCHER AVENUE  
WASHINGTON, D.C.

F. W. X

MARYLAND

LOCAL W. T. M. A.

CLAYTON O'CONNOR

SEPT. 1912

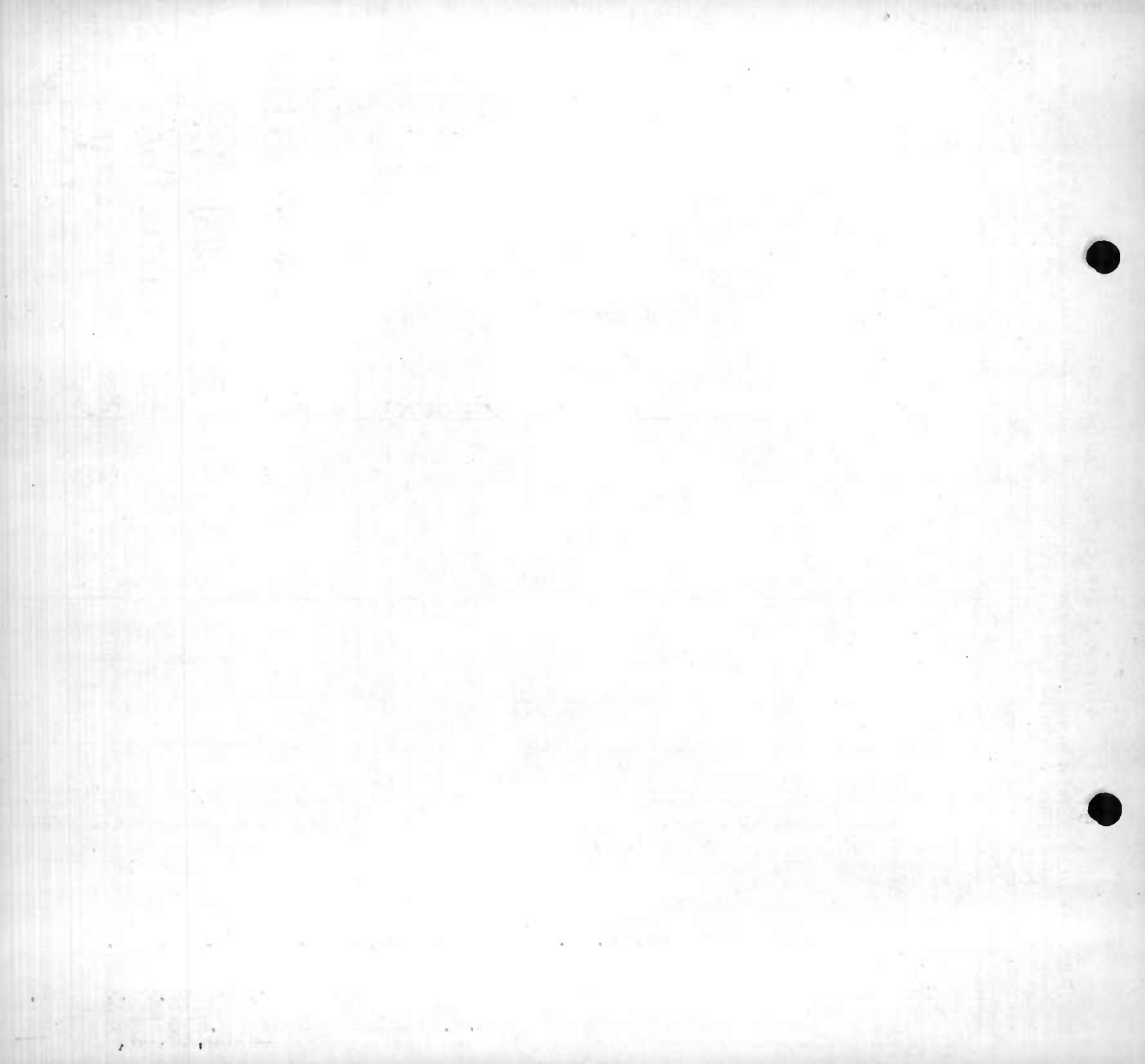
Sept 19 1912

Sept 19 1912

Sept 19 1912

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

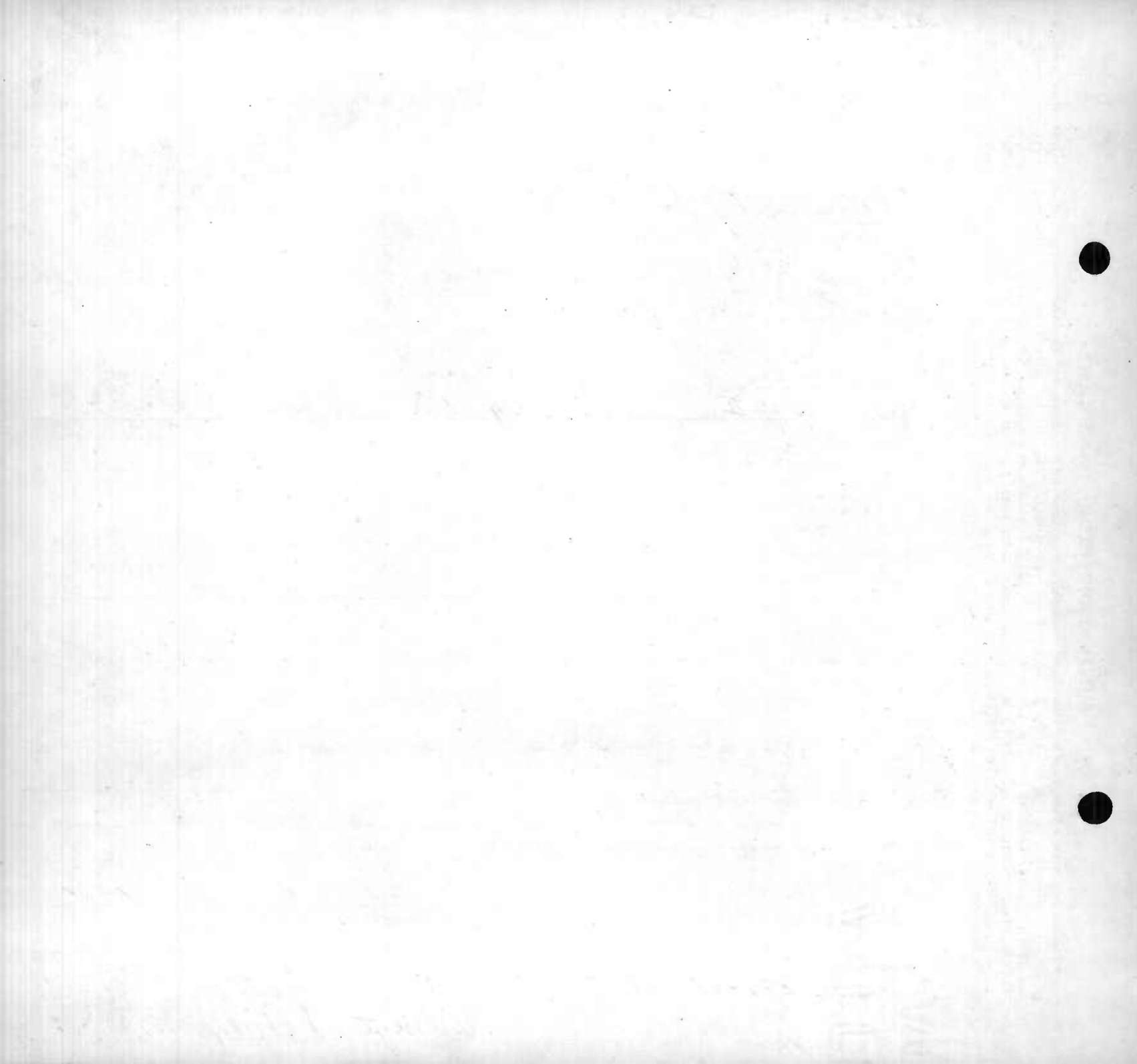
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4794	
<div style="display: flex; justify-content: space-between;"> <span>H-520 68- 4794</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <b>ADDIE HINES</b>			2. DATE AND HOUR OF DEATH <b>5/5/68 10<sup>30</sup> P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MERCY HOSP.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1406 LOCHNER RD. 21212</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-8-89</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Charles Rayton</b>		
14. MOTHER'S MAIDEN NAME <b>Margaret Peregray</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>ALBERT HINES (SAME)</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arrhythmia &amp; Cong. Heart Fail.</b> (B) <b>myocardial infarction</b> (C) <b>ASCVD</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 mins &amp; 8 hrs.</b> <b>8 hrs.</b> <b>years</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>5/5</b> 19 <b>68</b> to <b>5/5</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5/5</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Kenneth Stern, M.D.</b>			23B. DATE SIGNED <b>5/5/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>Kenneth Stern, M. D.</b>			23D. ADDRESS <b>Mercy Hospital, Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/9/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>Parkville, Balto. Co., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-516 68-4795				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4795	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ELISHA HUMPHREY</b>				2. DATE AND HOUR OF DEATH <b>5-2-68</b> <b>11:00</b> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>UNIVERSITY HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>BALTO. 21223</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1103 W. MULBERRY ST.</b>			
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/23/23</b>		9. AGE (In years lost birthday) <b>44</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONSTRUCTION WORKER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>DUFFY HUMPHREY</b>				14. MOTHER'S MAIDEN NAME <b>LULA HENDERSON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war & dates of service) <b>yes WWII</b>				16. SOCIAL SECURITY NO. <b>243-24-0619</b>		17. INFORMANT <b>William Humphrey</b>	
18. <b>366091</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>UPEMIA, SEC RENAL FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>PANCREATITIS AND LIVER FAILURE</b>				19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>UPEMIA, SEC RENAL FAILURE</b> (B) <b>PANCREATITIS AND LIVER FAILURE</b> (C) _____		ADDRESS <b>3904</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>370.3 II</b>							
19A. DATE OF OPERATION <b>4-2-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Medial Obstr.</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>3-24-68</b> 19 to <b>5-2-68</b> 19, that (1) (we) last saw the deceased alive on <b>5-2-68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>R. M. BEAZLEY</b>				23B. DATE SIGNED <b>5/2/68</b>		23C. PHYSICIAN'S NAME (Type) <b>R. M. BEAZLEY</b>	
23D. ADDRESS <b>UNIV. HOSPITAL -</b>				23E. DEGREE <b>MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>5-6-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Antioch</b>		24D. LOCATION (City, town, or county) (State) <b>Keinston N.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Urlington Phillips</b>		25D. ADDRESS <b>1727 N. Mount St.</b>	

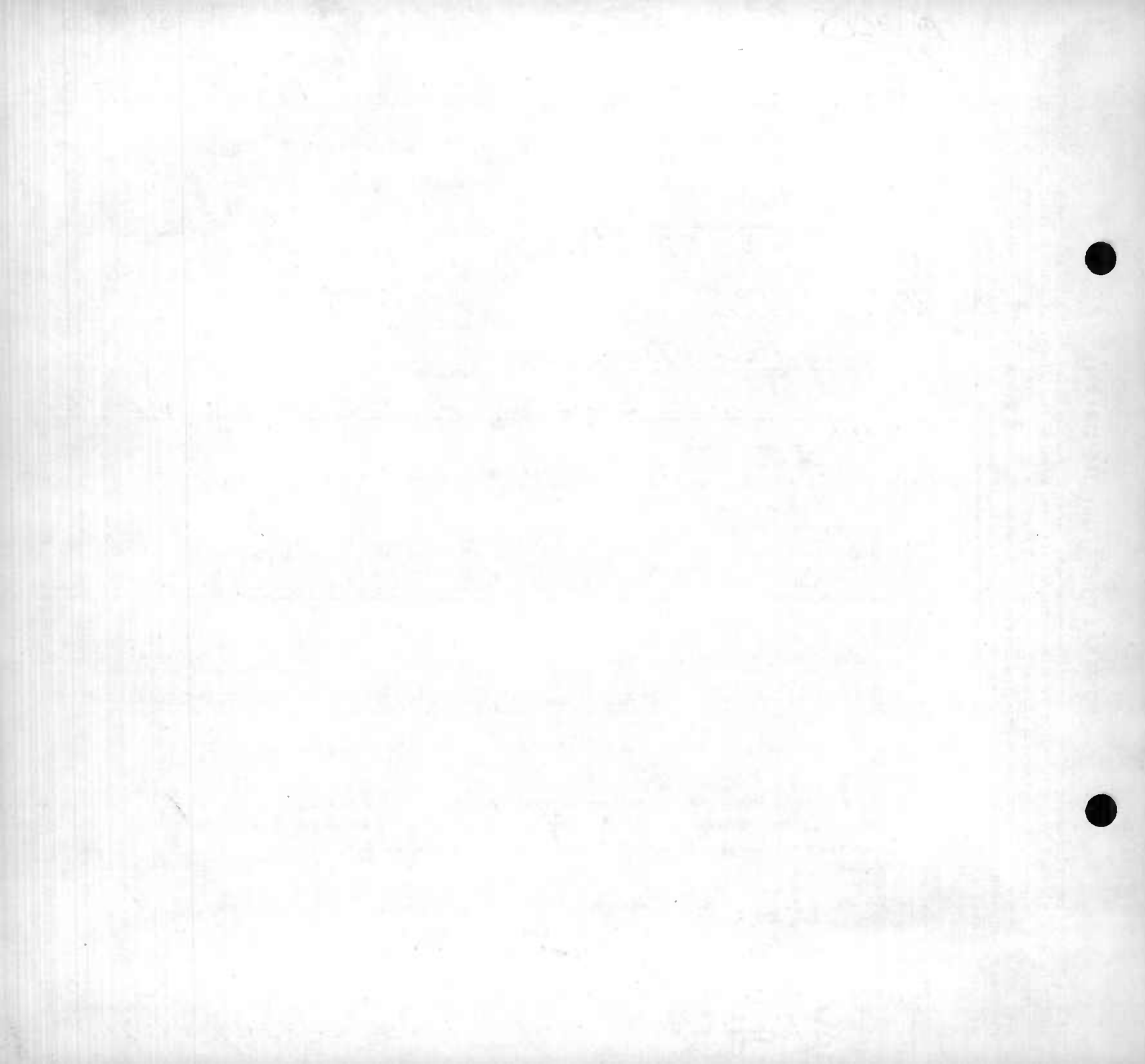




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4796
<b>B-200</b> <b>68- 4796</b> <b>CERTIFICATE OF DEATH</b>		<b>1. NAME OF DECEASED</b> (Type or Print) <u>Lucia Boone</u>		
<b>2. DATE AND HOUR OF DEATH</b> <u>5/14/68</u> <u>4:30</u> P.M.		<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Univ. of Maryland Hospital</u>		
<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		<b>5. STREET AND NUMBER</b> <u>1701 McCulloh ST</u>		
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>11/7/93</u>	<b>9. AGE</b> (In years lost birthday) <u>75</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>George Harrison</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Luvencia Kelley</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>213-20-9764</u>		<b>17. INFORMANT</b> <u>Mary Barnes</u>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Broncho pneumonia</u> (B) <u>Metastatic MAMMARY CANCER</u> DUE TO, OR AS A CONSEQUENCE OF: <u>4 yrs</u> (C) _____		
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <u>170X II</u>				
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>NO</u>		<b>20A. AUTOPSY?</b> (Yes or No) <u>NO</u>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from <u>4/13</u> 19<u>68</u> to <u>5/14</u> 19<u>68</u>, that (I) (we) last saw the deceased alive on <u>5/14</u> 19<u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>Sandra Z. Salan, MD</u>		<b>23B. DATE SIGNED</b> <u>5/14/68</u>		<b>23C. PHYSICIAN'S NAME</b> (Type) <u>SANDRA Z. SALAN MD</u>
<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal 5-5-68</u>		<b>24B. NAME OF CEMETERY or CREMATORY</b> <u>Fallar Mount</u>		<b>24C. LOCATION</b> (City, town, or county) (State) <u>Brunswick Co. VA.</u>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>MAY 7 1968</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor, MD</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Unglinton, Shultz, 1727 N. Howard St.</u>



B-420 68-4797 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 68-4797

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>MARY L BULLOCK</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Sinai Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 2, 1968 9:10 A.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Maryland</b>	
9. DATE OF BIRTH <b>3-4-1925</b>		10. AGE (In years last birthday) <b>43</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trucker</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Noland Bullock</b>		ADDRESS <b>Hampton, V.B.</b>	
19. <b>E814.7</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive pulmonary embolism</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Fracture of right femur</b>			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Slade Avenue 5' east of Reisterstown Road</b>		22F. HOW DID INJURY OCCUR? <b>Pedestrian struck by auto</b>	
22D. TIME OF INJURY (APPROX.) <b>3-30-68 7:00 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>May 2, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-7-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fickens</b>	
25C. FUNERAL DIRECTOR <b>Wilmington Phillips</b>		ADDRESS <b>1727 N. Monroe St.</b>	

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M-242 68- 4798 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. 68- 4798

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JAMES McLAUGHLAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 4, 1968</b> Hour <b>4:24 A.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3219 E. Baltimore Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 4, 1968</b> <b>4:25 A.</b> M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
6. SEX <b>Male</b>	7. RACE <b>White</b>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Oct. 6, 1919</b>		10. AGE (In years lost birthday) <b>49</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		E. STREET AND NUMBER <b>3219 E. Baltimore Street</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Jessie</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW-2</b>		17. SOCIAL SECURITY NO. <b>26-05-7665</b>		18. INFORMANT ADDRESS <b>Mary McLaughlan 3219 E. Baltimore St.</b>	
19. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E965X</b> <b>Gunshot wounds of chest and abdomen (.38)</b>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>E987X</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>3219 E. Baltimore Street</b> <b>E987X</b>	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>May 4, 1968 3:55 a.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject shot by son</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5-4-68</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>508-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto. Natl. Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fiedler</b>		25C. FUNERAL DIRECTOR ADDRESS <b>B. Dabrowski 2818 E. Baltimore St.</b>			

AT

DATE

FOR THE DEPARTMENT OF THE INTERIOR

TO THE SECRETARY OF THE

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BY

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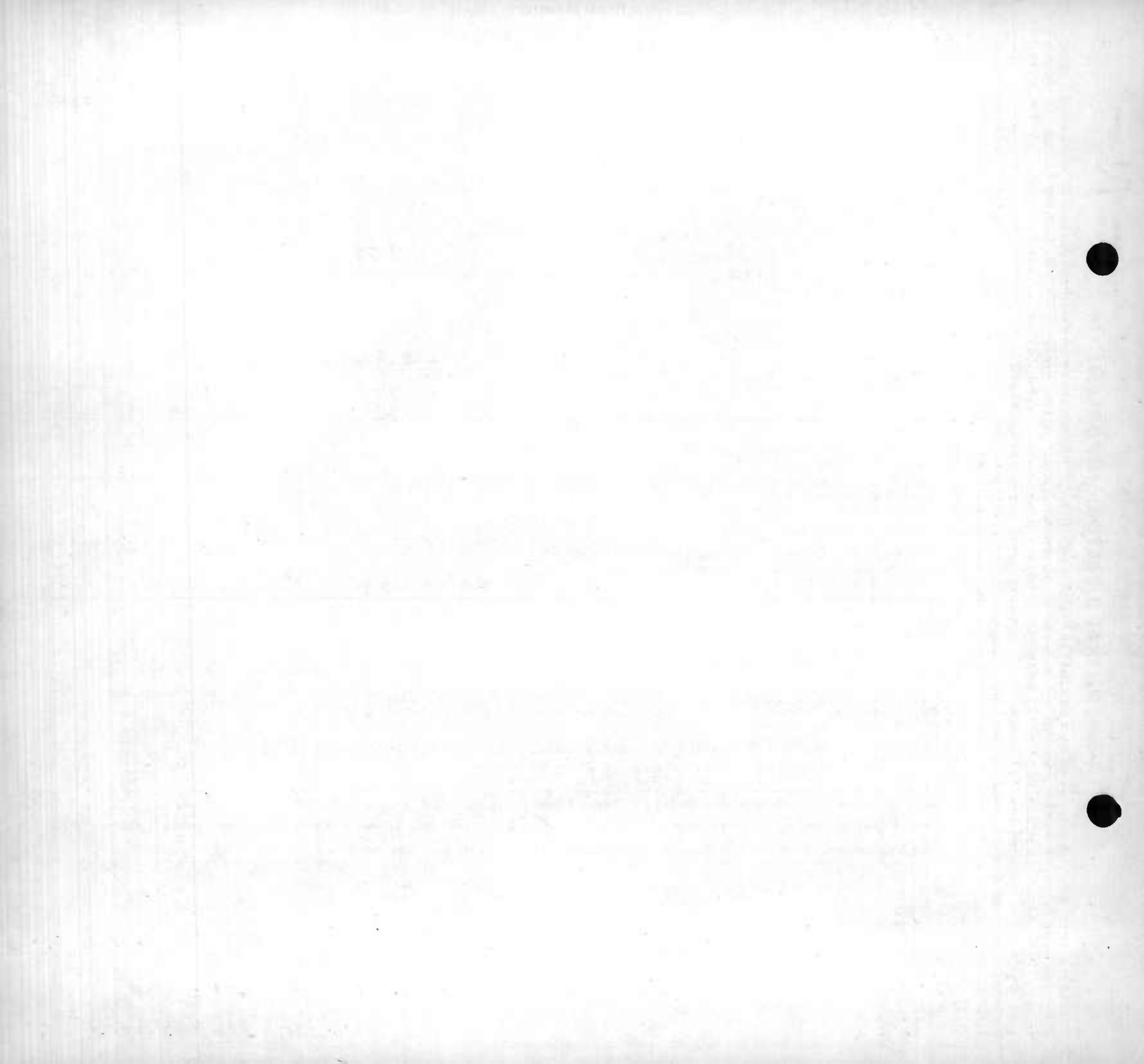
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 4799</b>	
<b>H-550 68- 4799 CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Hohman, Theresa</b>		2. DATE AND HOUR OF DEATH <b>5-3-68 9:55 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Baltimore</b> B. COUNTY <b>Maryland</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bolton Hill Nursing Center</b>			C. CITY OR TOWN <b>Maryland</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>1400 John Street</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/25/88</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Hohman, Aloysius</b>			14. MOTHER'S MAIDEN NAME <b>Stegman, Theresa</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Bolton Hill Nursing Center 1400 John St.</b>	
18. <b>412.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIO SCLEROSIS</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>arterio sclerosis</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>422.1 II</b>			(B) <b>arterio sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>year</b>		
			(C) <b>hypertensive</b> DUE TO, OR AS A CONSEQUENCE OF: <b>year 1967</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/1</b> 19 <b>66</b> to <b>5/3</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>5/3</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>ALLAN H. MACHT MD</b>				23B. DATE SIGNED <b>5/4/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALLAN H. MACHT MD</b>				23D. ADDRESS <b>2 E READ ST BALTIMORE MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/7/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Crm.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jankowski</b>		25C. FUNERAL DIRECTOR ADDRESS <b>B. DABROWSKI 2814 E. BALTO. ST.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
F-321 68-4800 CERTIFICATE OF DEATH									
REG. NO. 68-4800									
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DELIA BOURKE FITZPATRICK</b>							
		2. DATE AND HOUR OF DEATH <b>MAY 3, 1968</b> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSP.</b>					A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
					E. STREET AND NUMBER <b>3005 HARVIEW AVE.</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 20, 1889</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>		11. BIRTHPLACE (State or foreign country) <b>IRELAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S. D.</b>	
13. FATHER'S NAME <b>MICHAEL BOURKE</b>					14. MOTHER'S MAIDEN NAME <b>MARY COFFEY</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>217-20-6937</b>		17. INFORMANT ADDRESS <b>Lucyann Barty - 15 Charles Plaza</b>				
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>A. S. C. V. Disease years</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>422.1 II</b>									
19A. DATE OF OPERATION <b>5/3/68</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5/3</b> 19 <b>68</b> to <b>5/3</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2:30 P.M.</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <del>did</del> ) (did not) view the body after death.									
23A. SIGNATURE <b>Nathan Janney</b>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>5/6/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Nathan Janney</b>					23D. ADDRESS <b>7101 Harford Rd. Balto., Md. 21234</b>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>5-7-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cathedral Cem.</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>			25B. NAME OF REGISTRAR <b>R. L. E. Taylor</b>			25C. FUNERAL DIRECTOR ADDRESS <b>Farley-Corcoran &amp; F.H. Catorville Md.</b>			

20th Nov 1944  
The House of Commons  
London W.C.2

1  
S-260

68-4801 BALTIMORE CITY HEALTH DEPARTMENT

68-4801

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES

Shuck

~~SLUCK~~

2. DATE  
OF  
DEATH

Known ☐ Estimated ☐

Month Day Year

May 3, 1968

Hour 9:30 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST. AGNES HOSPITAL (DOA)

3. DATE  
PRONOUNCED DEAD

Month Day Year

May 3, 1968

Hour 9:30 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Howard

6. SEX  
Male

7. RACE  
White

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN  
Savage

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH  
6-11-1936

10. AGE (In years lost birthday) 31 30  
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

606 Washington Street

11. BIRTHPLACE (State or foreign country)  
W.Va

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Dave Shuck

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Truck Driver

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mable Wiles

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
No

17. SOCIAL SECURITY NO.  
235 50 7596

18. INFORMANT

ADDRESS 320 Madison, St. Frey Funeral Home, Fairmont, W.Va. 26554

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Craniocerebral Injury

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
Street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  
Howard County U.S. Rte. #1 Intersection of State Rte. #32

22D. TIME (Month) (Day) (Year) (Hour)  
May 3, 1968 9:02

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian struck by car

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-4-68

24A. BURIAL CREMATION, REMOVAL (Specify)  
Burial

24B. DATE

May 7, 1968

24C. NAME of CEMETERY or CREMATORY

Brummage Cemetery

24D. LOCATION (City, town, or county)

Fairmont, Marion W.Va.

25A. DATE REC'D BY HEALTH DEPT.

MAY 8 1968

25B. NAME OF REGISTRAR

Wm. Cook-Brooks

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks Towson, Towson, Md. 21204

000-2

STATE  
DEPT.

U.S. DEPT. OF STATE

1-1-1950

WFO

U.S.A.

STATE DEPT.

STATE DEPT.

STATE DEPT.

100 20 1950

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WALTER

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100 20 1950

100 20 1950

FUNERAL DIRECTOR: IMPORTANT

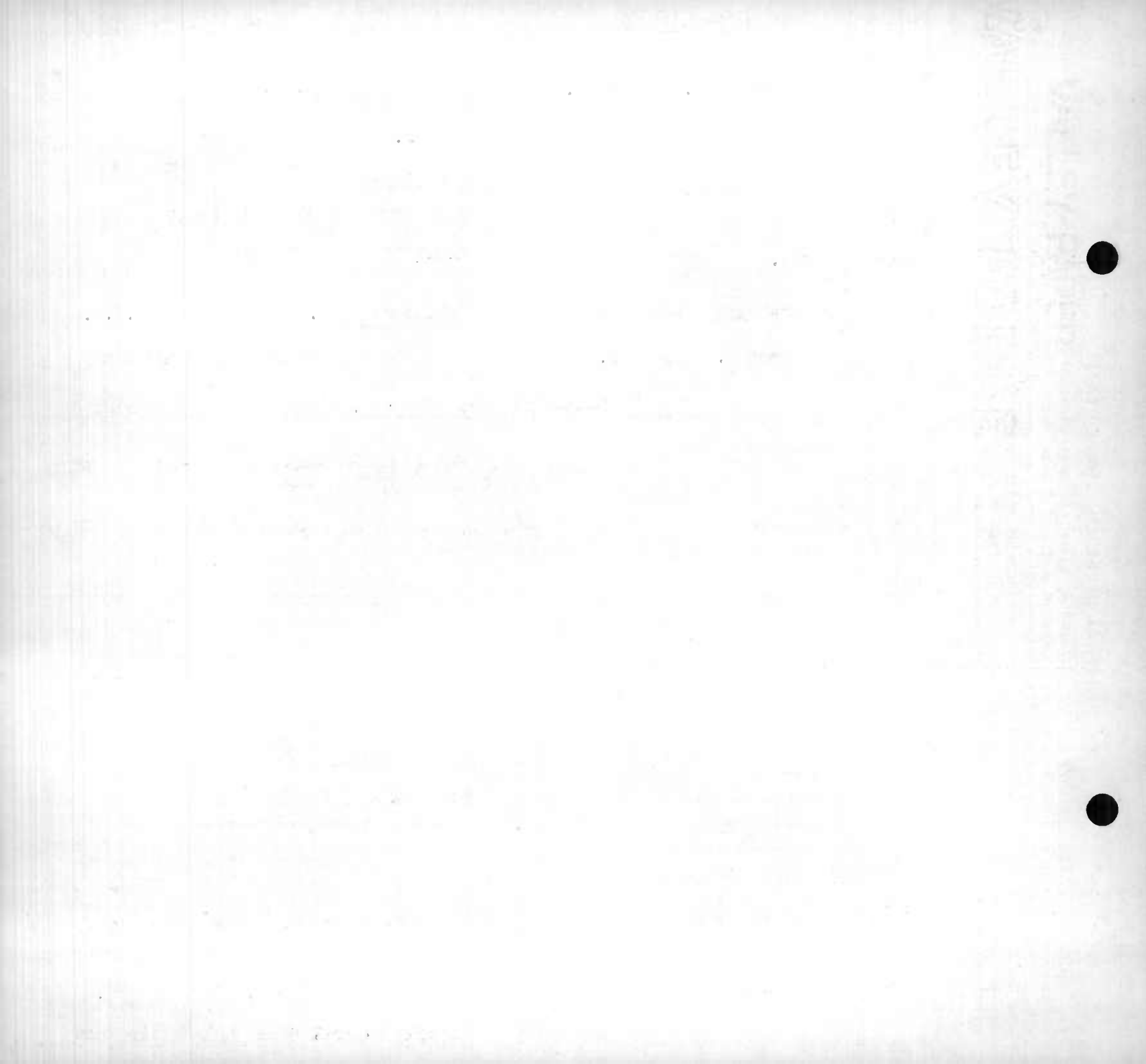
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-- 4802

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-- 4802

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Robert E. Forney Jr.		5-5-1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospital				A. STATE Md. B. COUNTY Baltimore	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 8409 Rocky Mount Road 21237					
5. SEX Male	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-1908	9. AGE (In years last birthday) 53	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Data Processing
10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel			11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert E. Forney Sr.			14. MOTHER'S MAIDEN NAME Charalotte Merchant		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-09-1327		17. INFORMANT Mrs Robert E. Forney 8409 Rocky Mount R
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 420.1 I Acute Coronary Thrombosis					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease 7 yr					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 6, 19 to 19, that (I) (we) last saw the deceased alive on 5/23, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. SADRANANDH				23B. DATE SIGNED 5/6/68	
23C. PHYSICIAN'S NAME (Type) V. SADRANANDH				23D. ADDRESS 6801 Belair Rd. Balto 6 Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-9-1968		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, City Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 8 1968		25B. NAME OF REGISTRAR Robert E. Forney		25C. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4803

CITY OF BALTIMORE HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

68-4803

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GUY W. STITELY

2. DATE AND HOUR OF DEATH

5/6/68

5:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

44

UNION

MEMORIAL

HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

811 GORSUCH

Avenue

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

2/7/03

9. AGE (In years last birthday)

65

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tool & Die Maker

10B. KIND OF BUSINESS OR INDUSTRY

Bendix Corp.

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

U. S. Grant STITELY

14. MOTHER'S MAIDEN NAME

Elizabeth Reiley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

153-01-5038

17. INFORMANT

MRS. ELE NORA V. STITELY

ADDRESS

811 GORSUCH AVE.

18.

39501

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

AORTIC

STENOSIS 40 YEARS

(B)

RHEUMATIC

FEVER

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 3 19 68 to May 6 19 68, that (I) (we) last saw the deceased alive on May 6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Enrique Cipriani M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

5/6/68

23C. PHYSICIAN'S NAME (Type)

ENRIQUE

CIPRIANI M.D.

23D. ADDRESS

33 and Calvert Sts.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5/9/68

24C. NAME of CEMETERY or CREMATORY

Burns Hill

24D. LOCATION

Waynesboro, Franklin Pa.

25A. DATE REC'D BY HEALTH DEPT.

MAY 8 1968

25B. NAME OF REGISTRAR

Robert E. Fickens

25C. FUNERAL DIRECTOR

Robert J. Fickens

ADDRESS

X

UNION  
MEMORIAL

Union

X

M

M

2/10/02

MEMORIAL

Pennsylvania

21 JULY

MAR. ELE. WARR. LIT.

RECEIVED

NO

CO. 3000  
2/10/02

2/10/02

2/10/02

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4804

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4804

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JULIA A. JENNESS</b>		2. DATE AND HOUR OF DEATH <b>May 3 1968 18 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>3021 Huntington Ave. Baltimore, Md. 21211</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>207</b>
5. SEX <b>Female</b>		6. RACE <b>cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>8-28-87</b>	
13. FATHER'S NAME <b>Edward Hahn</b>		14. MOTHER'S MAIDEN NAME <b>Kathleen Link</b>		9. AGE (In years last birthday) <b>80</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>medical chart</b>	
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>arterio sclerotic cardiovascular disease over 25 years</b> DUE TO, OR AS A CONSEQUENCE OF: <b>C.V.A.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Chemo.</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>422.1 II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept.</b> 19 <b>54</b> to <b>April 25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>April 25</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>T. Chandler M.D.</b>				23B. DATE SIGNED <b>May 6, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>502 T. Chandler M.D.</b>				23D. ADDRESS <b>The Union Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/6/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>LODGE PARK</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>			
25B. NAME OF REGISTRAR <b>Paul E. Chandler</b>		25C. FUNERAL DIRECTOR <b>Paul E. Chandler</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. N-130		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4805	
1. NAME OF DECEASED (Type or Print) IRVIN NEVITT			2. DATE AND HOUR OF DEATH 5 MAY 1968 8 <sup>20</sup> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224			A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN 53-00 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 6/21/59 9. AGE (In years lost birthday) 8		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) MD		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM			14. MOTHER'S MAIDEN NAME MARION		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) NO			17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224		
16. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
16A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia		
16B. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)			(B) Laceration axillary artery 5 days		
16C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 24 Chandelie Rd 53-00	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 3-1-68 7 <sup>10</sup> PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? INTO HOUSE STRUCK STORM DOOR WHILE COMING?	
22. I certify that (I) (this hospital) attended the deceased from 1 MAY, 1968 to 5 MAY, 1968, that (I) (we) last saw the deceased alive on 5 MAY, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel D. Foote MD			23B. DATE SIGNED 5 MAY, 1968		
23C. PHYSICIAN'S NAME (Type) DANIEL D. FOOTE			23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/8/68		24C. NAME OF CEMETERY or CREMATORY ST. MARY'S	
24D. LOCATION (City, town, or county) (State) BALTO. MD.					
25A. DATE REC'D BY HEALTH DEPT. MAY 8 1968		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Paul E. Charon	
				ADDRESS 3617 Chartwell Ave	

Handwritten text, possibly a signature or date, located in the center of the page.

S-163

68- 4806 BALTIMORE CITY HEALTH DEPARTMENT

68- 4806

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Carroll</b> <b>RAYMOND/SHEPHERD</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>5</b> <b>5</b> <b>68</b> <b>11:05a</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Mallview Road</b> <b>2979 Mallview Road</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May</b> <b>5</b> , <b>1968</b> <b>11:05 a.m.</b>	
6. SEX <b>Male</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
7. RACE <b>White</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>2979 Mallview Road</b> <b>2979 Mallview Road</b> <b>21230</b>	
9. DATE OF BIRTH <b>May 11, 1924</b>		10. AGE (In years lost birthday) <b>43</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Esskay Meat Products</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WW 11</b>		17. SOCIAL SECURITY NO. <b>219-18-1863</b>	
18. INFORMANT <b>Mrs. Jacqueline Shepherd</b>		ADDRESS <b>2979 Mallview Road</b>	
19. <b>E 922.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of the head</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Gunshot wound of the head</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION <b>2919.0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22D. TIME OF INJURY (APPROX.) <b>5</b> <b>5</b> <b>68</b> <b>10:45a</b>		22E. INJURY OCCURRED <b>WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Mallview Rd</b> <b>2979 Mallview Rd.</b> (Kitchen)		22F. HOW DID INJURY OCCUR? <b>Subject accidentally shot</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>May 6, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/9/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Folsom</b>	
25C. FUNERAL DIRECTOR <b>McCally F. H.</b>		ADDRESS <b>237 Patapsco Ave. 21225</b>	



5

7

Subject location

2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 4807 CERTIFICATE OF DEATH

REG. NO. 68- 4807

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Mrs LAURA C COOPER</b>		2. DATE AND HOUR OF DEATH <b>5/6/68</b> <b>8:35 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Md. Gen'l Hosp.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTO.</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		B. DATE OF BIRTH <b>1-16-87</b>	
		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>81</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>	
13. FATHER'S NAME <b>Charles Kaelin</b>		14. MOTHER'S MAIDEN NAME <b>P (Unknown)</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214249834</b>		17. INFORMANT <b>ALLEN HUBBARD</b>	
				ADDRESS <b>Same</b>	
18. <b>153.8</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		<b>Metastatic Carcinoma Colon</b>		<b>3 yrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>153.8 II</b>					
19A. DATE OF OPERATION <b>1965</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA of Colon</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>4/24</b> <b>1968</b> to <b>5/6</b> <b>1968</b> , that (I) (we) last saw the deceased alive on <b>5/6</b> <b>1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>F. J. Zorick MD</b>				23B. DATE SIGNED <b>5/6/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>F. J. ZORICK MD</b>				23D. ADDRESS <b>MD. Gen'l Hosp BALTO</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-9-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	

8-27-41

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-- 4808

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-- 4808

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LAWRENCE F. STOCK, SR

2. DATE AND HOUR OF DEATH

5/4/68

P: 30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

46 LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

MARYLAND

B. COUNTY

Baltimore

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

1222 MAPLE AVE. ARBUTUS

5. SEX

M

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

11/19/05

9. AGE (In years  
last birthday)

62

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

ENGINEER

10B. KIND OF BUSINESS OR INDUSTRY

I.B.M.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

FRANK STOCK

14. MOTHER'S MAIDEN NAME

Mary PHILIP

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

213-10-0183

17. INFORMANT

FROM CHART.

ADDRESS

18. 436.9 4250.9

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE ASPIRATION PNEUMONIA  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) C. V. A  
DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

331X II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

DIABETES MELLITUS

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/13/1968 to 5/4/1968,  
that (I) (we) last saw the deceased alive on 5/4/1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David Khou

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5/4/68.

23C. PHYSICIAN'S  
NAME (Type)

DAVID KHOU

DEGREE

23D. ADDRESS

LUTHERAN HOSPITAL.

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5/7/68

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 8 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

Ambrose Inc. 1328 Sulphur Sp. Rd.

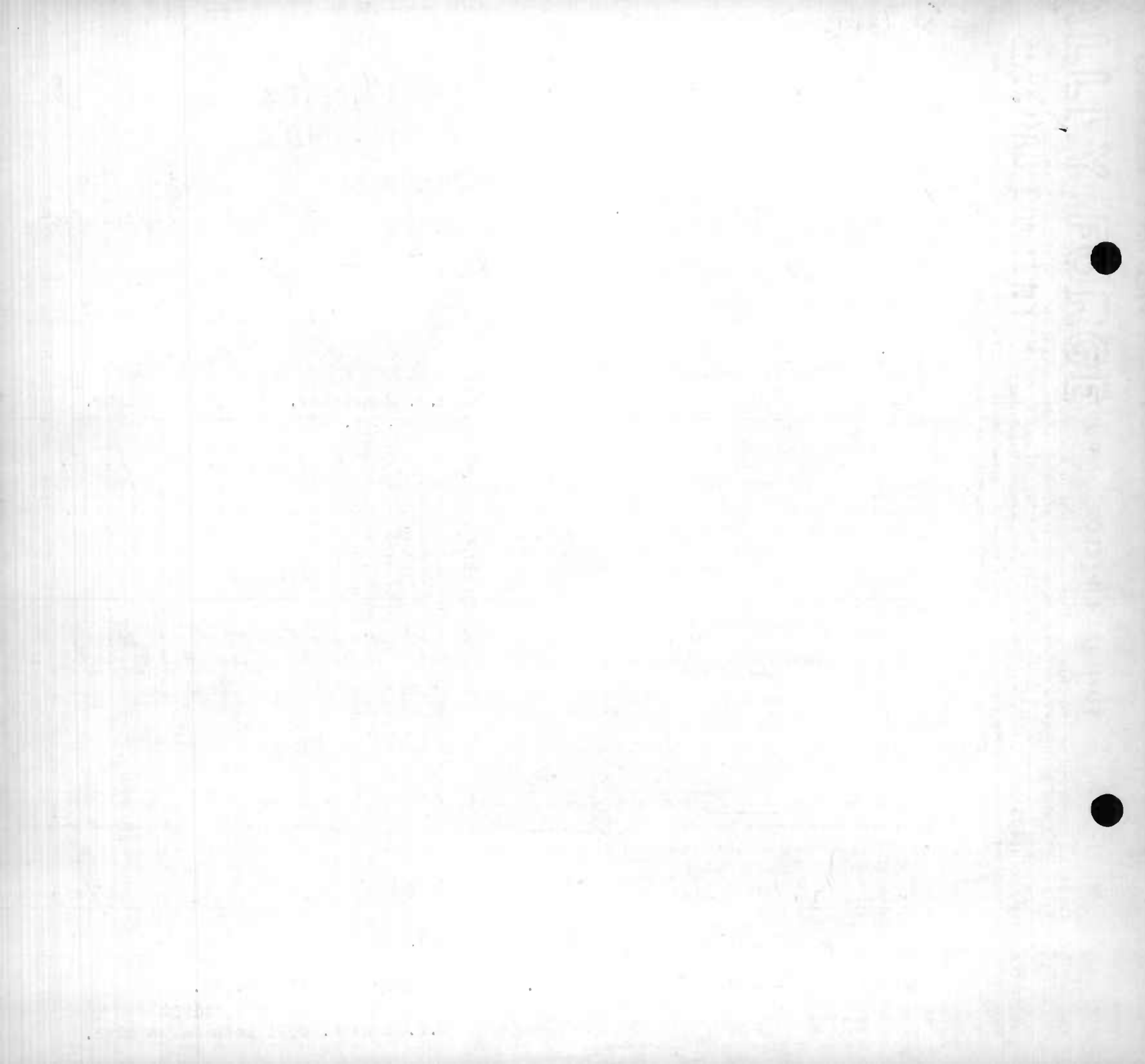
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>5-616</span> <span>68-4809</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.5em;">68-4809</span>	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MRS. Ethel L. SCHREIBER</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">4/30/68 1:00 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">MERCY HOSPITAL, INC.</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY _____ C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">1321 E. BELVEDERE AVE.</span>	
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">11-4-94</span>
9. AGE (In years lost birthday) <span style="font-size: 1.2em;">73</span>		If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____	10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>
10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Home</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">BALTIMORE, MD.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">EDWARD SUEHLE</span>	
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">FRANCES REICHEL</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Thos. S. Schrieber, 8714 Beechwood Dr.</span>	
18. <span style="font-size: 1.2em;">394.01</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <span style="font-size: 1.2em;">Fairfax, Va. 22030</span>  (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Severe Mitral Stenosis</span> DUE TO, OR AS A CONSEQUENCE OF:  (B) <span style="font-size: 1.2em;">Rheumatic Heart Disease</span> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">years</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">years</span>	
19. <span style="font-size: 1.2em;">410X II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.2em;">urinary tract infection</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">days</span>	
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2-1-68</span>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">yes</span>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">No</span>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) _____	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">4/23/68</span> 19____ to <span style="font-size: 1.2em;">4/30/68</span> 19____, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4/30/68</span> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">David S. McHold MD</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">4/30/68</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">DAVID S. McHOLD MD</span>		23D. ADDRESS <span style="font-size: 1.2em;">MERCY Hosp.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">5-3-68</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Moreland Mem. Park Cemetery</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 8 1968</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">W.E. Johnson, 8521 Loch Raven Blvd.</span>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Minnie Elizabeth Stoll</b>		2. DATE AND HOUR OF DEATH <b>5-6-68 7<sup>30</sup> AM</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b> <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>ESSEX</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>907 Martin Road</b> <b>21221</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-11-1893</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Milton Pfender</b>				14. MOTHER'S MAIDEN NAME <b>Minnie</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>5-31-91</b> <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>? Breakdown of anastomosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Post-op Total Gastrectomy</b> (C) <b>Ulcer diathesis (Z-E Syndrome)</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 Hours</b>							
19A. DATE OF OPERATION <b>5-1-68</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ZOLLINGER-ELLISON SYNDROME</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-26-</b> <b>19 68</b> to <b>5-6-</b> <b>19 68</b> , that (I) (we) last saw the deceased alive on <b>5-6-</b> <b>19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Paul Kryger, MD</b>				23B. DATE SIGNED <b>5-6-68</b>		23C. PHYSICIAN'S NAME (Type) <b>Paul Kryger</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>5-7-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Locustwood Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Cherry Hill New Jersey</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. F...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Connolly Funeral Home - 300 Grace Ave.</b>			

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RALPH C. DOWDY

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

5

6

68

6:44a

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

May

6

1968

6:44a

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

6/5/17

10. AGE (In years  
last birthday)

51 50

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

17 W. Preston St.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

T. T. Dowdy

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Odd jobs

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Myrtle Dowdy 17 W. Preston St.

19. 412.21

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)Hypertensive arteriosclerotic cardiovascular  
disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 6, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

24B. DATE

5/7/68

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

Lynchburg, Va.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 8 1968

25B. NAME OF REGISTRAR

Edmund E. Fairbank

25C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks Inc. 1217 St. Paul St.

Franklin

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

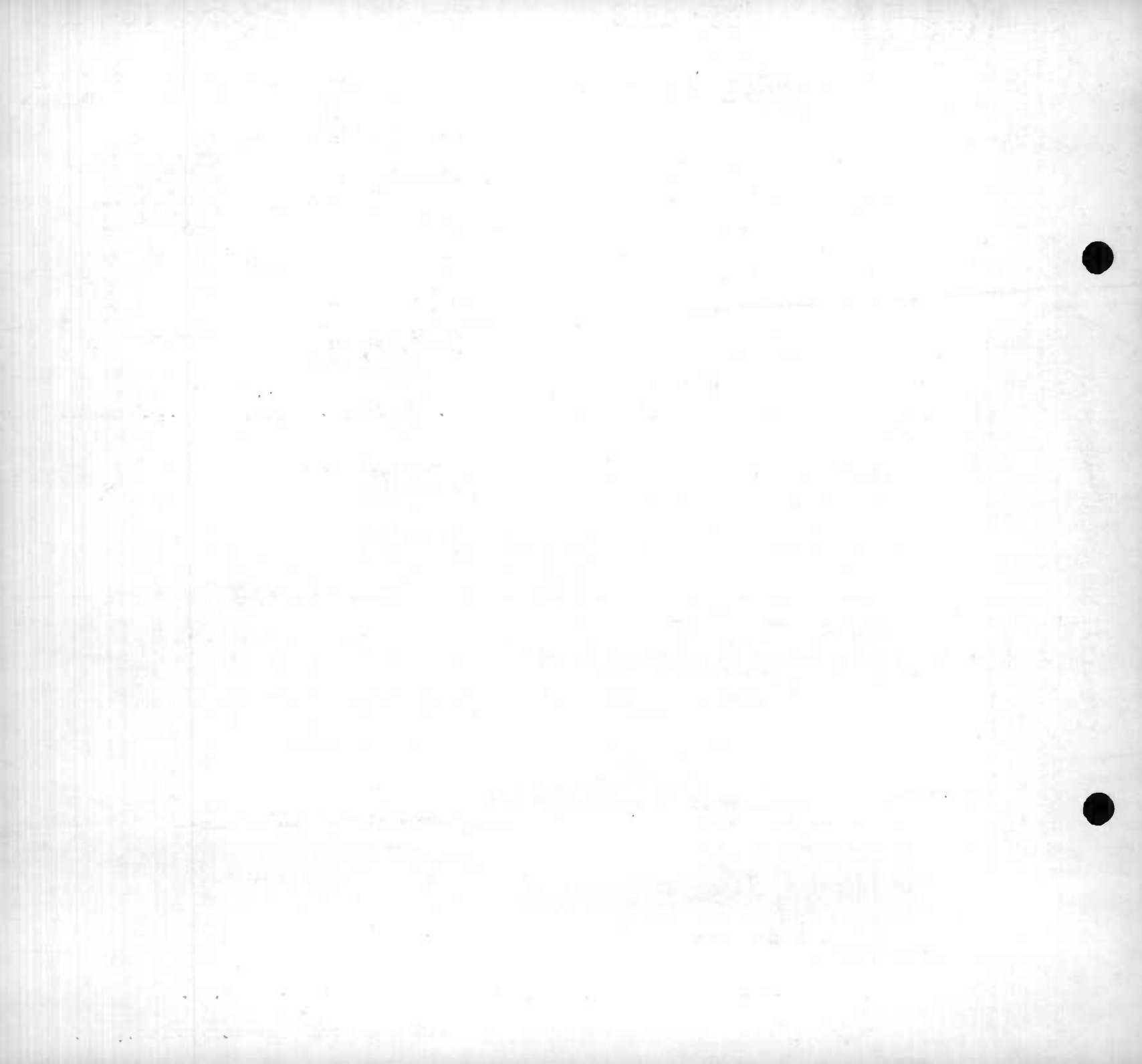
68- 4812

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 4812

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARGARET CLEMENTS</b>		2. DATE AND HOUR OF DEATH <b>MAY 7, 1968</b> <b>8<sup>55</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO Co</b>		5. STREET AND NUMBER <b>1126 St. AGNES Lane</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hospital</b> <b>34 FAYETTE + Pulaski St.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-11-80</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>FRANK Thompson</b>		14. MOTHER'S MAIDEN NAME <b>ROBEY, Martha</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. William G. Lowry, Balto., Maryland 21207</b>	
18. <b>153.8 I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Intestinal obstruction</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Cancer of colon.</b> DUE TO, OR AS A CONSEQUENCE OF:			
19. <b>153.8 II</b>		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 7</b> 19 <b>68</b> to <b>May 7</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Garcia</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>J.G. Amayo</b>				23D. ADDRESS <b>Bon Secours Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-10-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>	
24D. LOCATION <b>Washington, D. C.</b>		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Dr. E. J. Taylor</b>		25C. FUNERAL DIRECTOR <b>Witzke Funeral Directors, Balto., Md. 21229</b>	
25D. ADDRESS <b>4101 Edmondson Avenue</b>		25E. (City, town, or county)			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4813

BALTIMORE CITY HEALTH DEPT.  
CERTIFICATE OF DEATH

REG. NO.

68- 4813

BIRTH NO. <span style="float: right;">52</span>		1. NAME OF DECEASED (Type or Print) <b>Mc Nicholas Robert</b>		2. DATE AND HOUR OF DEATH <b>5/5/68 9:01 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore City</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
E. STREET AND NUMBER <b>North Avenue 309 E.</b>		5. SEX <b>Male</b> 6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>5/5/68 9/45</b>		9. AGE (In years last birthday) <b>72 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cooper</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Penalty Railroad</b>		11. BIRTH PLACE (State or foreign country) <b>Texas, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>America</b>		13. FATHER'S NAME <b>William Mc Nicholas</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Price</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>7-15-8-8157</b>		17. INFORMANT <b>Sister Antio Juley</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>250.9 + 141.9</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE - <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Diabetes, A.S.C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Carcinoma of Tongue with Metastases</b> <b>W.K.W.</b>			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>260X II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (was hospital) attended the deceased from <b>5/5/68</b> to <b>5/5/68</b> and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>DERMOT CAMPBELL M.B.</b>				23B. DATE SIGNED <b>5/5/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>DERMOT CAMPBELL M.B.</b>				23D. ADDRESS <b>Union Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-8-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Balto., Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Juley</b>	
24G. FUNERAL DIRECTOR <b>Witzke Funeral Directors, Balto., Md.</b>		24H. ADDRESS <b>4101 Edmondson Avenue</b>		24I. CITY, STATE, ZIP <b>BALTO., MD. 21229</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 4814</b>
BIRTH NO. <b>68- 4814</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>Burley Hagnie E.</b>		2. DATE AND HOUR OF DEATH <b>5-4-68 10:25 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital, Inc.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>23-01</b>		
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>L</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>H adnie Burley</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Johnson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ruben Nicholas- Stepson</b>
				ADDRESS <b>1116 Carson Ct.</b>
18. <b>269.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Dehydration, Malnutrition</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Hypotension</b>		
19. DATE OF OPERATION <b>286.5 II</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from <b>May 4, 1968</b> to <b>May 4, 1968</b> , that (I) (we) last saw the deceased alive on <b>May 4, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>GREGORIO S. TENGO</b>		23B. DATE SIGNED <b>5-6-68</b>		
23C. PHYSICIAN'S NAME (Type) <b>GREGORIO S. TENGO</b>		23D. ADDRESS <b>1514 Division Street Balto., Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-8-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Ct</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore City</b>				
25A. DATE RECEIVED BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Isaiah L. Brown And Son</b>
				ADDRESS <b>108 W. Montgomery Street</b>

Charles W. Smith  
Secretary

Wm. H. Smith

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4815	
<div style="display: flex; justify-content: space-between;"> <span><b>F-652</b></span> <span><b>68-4815</b></span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>					
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>SALVATORE/ Samuel FRANCO JR</b>		2. DATE AND HOUR OF DEATH <b>5-2-68 3<sup>35</sup> P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>  C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>518 MAUDE AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-29-09</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Depot Manager</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>		11. BIRTH PLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>SALVATORE FRANCO SR.</b>		14. MOTHER'S MAIDEN NAME <b>THERESA BROCATO</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>189-18-4637</b>		17. INFORMANT ADDRESS <b>Salvatore J. Franco - 518 Maude Ave.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Septicemia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Metastatic Hypernephroma</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>4 yrs.</b>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>180x II</b>					
19A. DATE OF OPERATION <b>Sept 67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/2/68</b> 19 to <b>5/2/68</b> 19 that (I) (we) last saw the deceased alive on <b>5/2</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>George H Reed MD</b> DEGREE				23B. DATE SIGNED <b>5/2/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>GEORGE H REED MD</b> DEGREE				23D. ADDRESS <b>Johns Hopkins Hosp</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fadden</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George J. Gonce-4001 Ritchie Hwy., Baltimore</b>			

2-5-21

2 specimens  
Histiotus hippocrepus

2/1/21

2/5

2/1/21

2/5

2/5/21

George H. H. H.

George H. H. H.

1  
L-250

68- 4816 BALTIMORE CITY HEALTH DEPARTMENT

68- 4816

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>LESLIE B. LAWSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>May 7, 1968</b> 5:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1704 Lexington Street (West)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 7, 1968</b> 8:15 A.M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>FEB 12 - 1944</b>		10. AGE (In years lost birthday) <b>44</b>	
11. BIRTHPLACE (State or foreign country) <b>SO BOSTON VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>DETHLEHEM STEEL</b>	
15. MOTHER'S MAIDEN NAME <b>MATTIE WYNN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>215-14-9726</b>		18. INFORMANT <b>EMMA JACKSON 1704 W LEXINGTON ST</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carcinomatosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>199.0</b>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>199.2</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinomatosis</b>	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>199.2</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)  22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?  23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		DATE SIGNED <b>5/7/68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>5/11/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT AUBURN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTD MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>	
25C. FUNERAL DIRECTOR <b>Harman P. Hays</b>		ADDRESS <b>638 N 612 MD ST</b>	

WALLLEY BOOTH CO.

257 N. 1st St. St. Paul, Minn.

WALLLEY BOOTH CO.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

162

68-4817

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-4817

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Virginia Iversen</u>		2. DATE AND HOUR OF DEATH <u>5/6/68</u> <u>11:50</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-12</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Johns Hopkins Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>5/17/10</u>		9. AGE (In years last birthday) <u>57</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia, Halifax Co., USA.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Patterson Jennings</u>		14. MOTHER'S MAIDEN NAME <u>Sally Graves</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>116-18-5234</u>		17. INFORMANT <u>MR. William Jones</u> ADDRESS <u>2205 Mc Elden</u>	
18. <u>188 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> (B) <u>Pelvic abscess</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Bladder Carcinoma</u>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Terminal Sigmoid Fistula</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
181.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION <u>3/4/15/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Recurrent Bladder Carcinoma</u>	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4</u> <u>1968</u> to <u>5/6/1968</u> , that (I) (we) last saw the deceased alive on <u>5/4/68</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert W. Swan, M.D.</u>		23B. DATE SIGNED <u>5/6/68</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>ROBERT W. SWAN, M.D.</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-11-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. STATE <u>Md</u>		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 8 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Moeten &amp; Dyett F.H.</u> ADDRESS <u>1701 LAURENS ST</u>	

21 10 21  
11/10/21

10 10 21

21

ROBERT W ZWANN, MD  
JOHN A HOPKINS HOSPITAL  
Baltimore, Md  
Director, Dept of Medicine

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 4818

BIRTH NO. 68- 4818  
16-01375

1. NAME OF DECEASED  
(Type or Print)

TYRONE BULLOCK

2. DATE AND HOUR OF DEATH

4 May 1968

1:02 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

BALTIMORE CITY

C. CITY OR TOWN  
BALTIMORE

D. INSIDE CITY LIMITS?  
YES ☒ NO ☐

E. STREET AND NUMBER

203 PARRISH STREET

21213

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-24-66

9. AGE (In years lost birthday)

2

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN BULLOCK

14. MOTHER'S MAIDEN NAME

VIRGINIA NUTT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
-0-

17. INFORMANT

Mr. John Bullock

ADDRESS

1827 Lorman St

18. 347.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

BRAIN STEM HERNIATION

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

~ 72 Hrs.

(B) INCREASED INTRACRANIAL  
DUE TO, OR AS A CONSEQUENCE OF:

PRESSURE

~ 72 Hrs.

(C) INTRACRANIAL LESION - UNKNOWN  
TYPE

~ 372 Hrs.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/19 1968 to 5/4 1968 that (I) (we) last saw the deceased alive on 5/4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Tom B. Vaughan, Jr.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4 May 1968

23C. PHYSICIAN'S NAME (Type)

TOM B. VAUGHN

23D. ADDRESS

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5-7-68

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Pk.

24D. LOCATION (City, town, or county)

Baltimore,

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

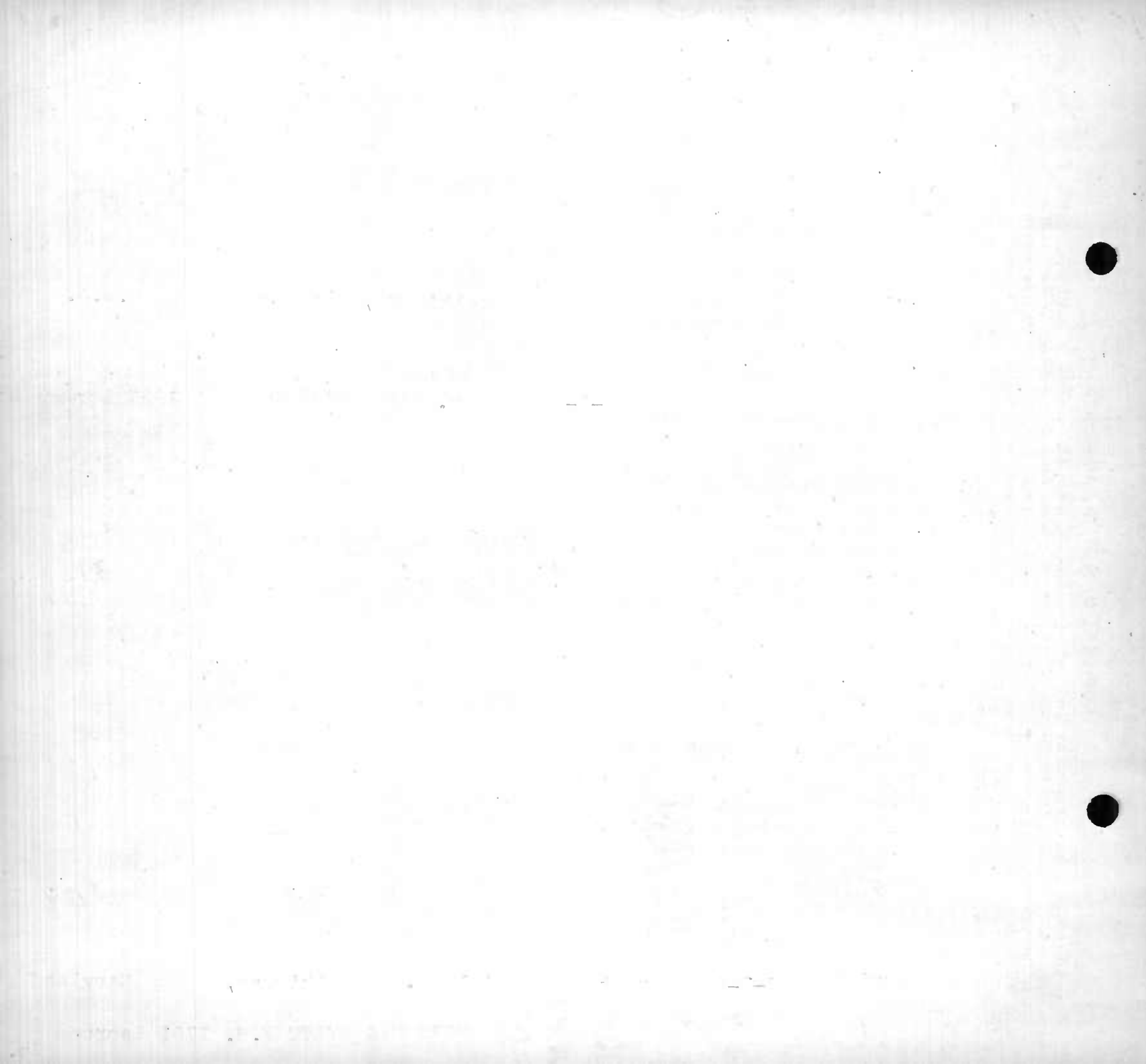
25C. FUNERAL DIRECTOR

ADDRESS

MAY 8 1968

Robert E. Fisher

MORTON & DYETT F.H. 1701 Laurens St



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4819	
BIRTH NO. 68- 4819		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOSEPH H. MADISON</b>			2. DATE AND HOUR OF DEATH <b>May 6, 1968 6:15 P M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>2256 Brookfield Avenue</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>13-02</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2256 Brookfield Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-8-1896</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PRINCE EDWARD CO., VA.</b>	
13. FATHER'S NAME <b>HENRY MADISON</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Lorraine Madison 2256 Brookfield</b>
18. <b>4319 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL HEMORRHAGE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>331X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/6/68</b> <b>8/12/65</b> 19 to <b>5/6/68</b> 19 that (I) (we) lost saw the deceased alive on <b>5/6/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>HOLLIS JENNAINE</b>				23B. DATE SIGNED <b>5/7/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>HOLLIS JENNAINE</b>				23D. ADDRESS <b>930 W. FELLOWS ST. BALT, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-10-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem. Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, Jr.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				REG. NO. 68-4820	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GLADYS M. JOHNSON</b>		2. DATE AND HOUR OF DEATH <b>May 5 1968</b> <b>8 A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balt</b>		C. CITY OR TOWN <b>Balt</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 Community Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>514/68 Montebello St Nasp</b>		E. STREET AND NUMBER	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/26/22</b>	9. AGE (In years lost birthday) <b>46</b>	Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland Carroll Co, USA</b>	
13. FATHER'S NAME <b>William Washington</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Halsey</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-12-6042</b>		17. INFORMANT <b>Old Chant</b> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.9 I Renal failure</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II Disseminated Sclerosis</b>					
19A. DATE OF OPERATION <b>4/20/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 1 1968</b> to <b>May 5 1968</b> , that (I) (we) last saw the deceased alive on <b>May 5 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stephen Hameroff</b>		DEGREE		23B. DATE SIGNED <b>5/6/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Stephen Hameroff</b>		DEGREE		23D. ADDRESS <b>Community Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-10-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Friendship Ch. Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Damascus Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Morton E. Dyett F.H.</b>		ADDRESS <b>1701 Laurens</b>			



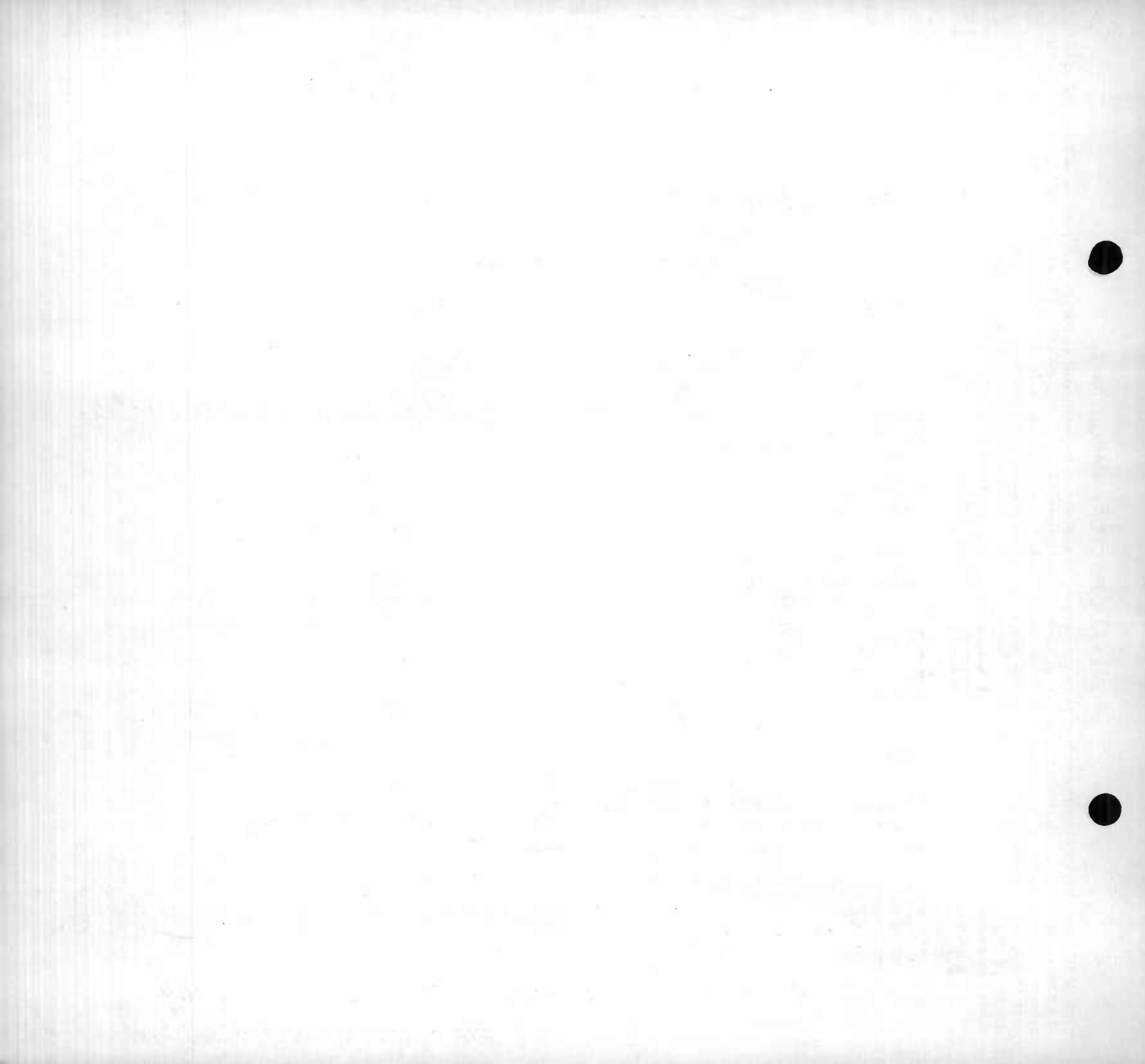
5/14/68 - Letter from University Hospital, Mrs. Helen King, Director, Dept. of Medical Records.

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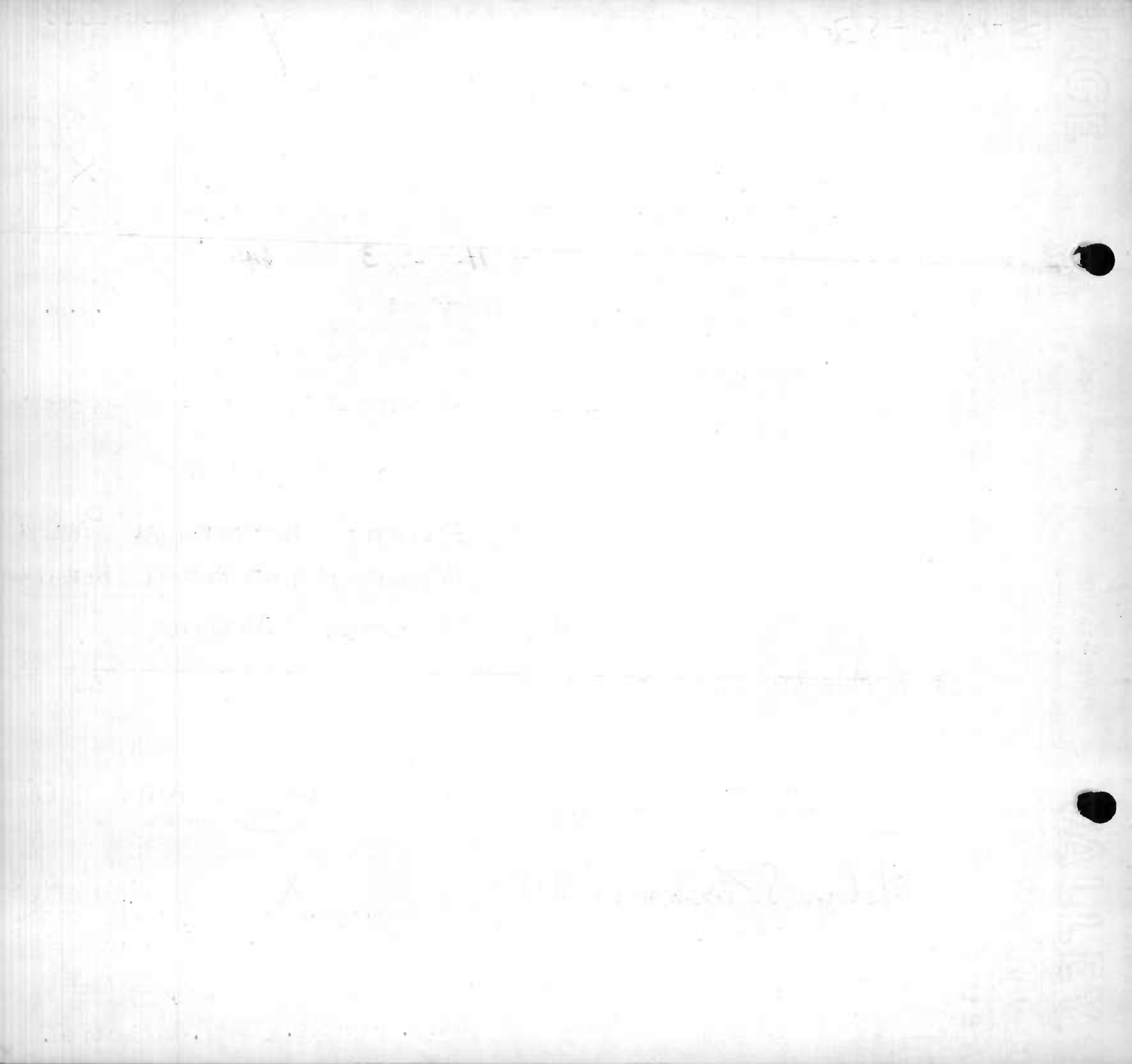
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-4821	
<div style="display: flex; justify-content: space-between;"> <span>68-4821</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>M.E. CASE NO.</b> 1. NAME OF DECEASED (Type or Print) <i>Grace E Kissick</i>		2. DATE AND HOUR OF DEATH <i>5/6/68 17:50 p.</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Crawford Retreat N.H</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write P.O. and give town or city) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1409 W. Lombard St</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>NEVER MARRIED</i>	8. DATE OF BIRTH <i>9-1881</i>	9. AGE (In years last birthday) <i>86</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Kissick</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Briel</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mrs A. M. Dyatt - 916 Evesham</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>575X I</i> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Cholecystitis</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>585X II</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/13</i> 19 <i>61</i> to <i>5/6</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5/6</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert A. Reiter</i>				23B. DATE SIGNED <i>5/6/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert A. Reiter</i>		23D. ADDRESS <i>606 Edmondson Ave 21228</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-8-68</i>		24C. NAME of CEMETERY or CREMATORY <i>Louisa Park Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 8 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taney</i>		25C. FUNERAL DIRECTOR <i>Ellsworth Armacost - 4600 Liberty Heights Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SMITH, WALTER H</b>		2. DATE AND HOUR OF DEATH <b>7 MAY 1968 13<sup>00</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>703 A Bauernschmidt Road 21221</b>		B. DATE OF BIRTH <b>11-27-1903</b>		9. AGE (In years last birthday) <b>64</b>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Inspector</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Henry H. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Florence Knight</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-8230</b>		17. INFORMANT <b>Records: BCH-4940 Eastern Avenue 21224</b>	
18. <b>431.041 250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>RESPIRATORY ARREST</b> (B) <b>ELEVATED INTRACRANIAL PRESSURE</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>MASSIVE INTRACEREBRAL HEMORRHAGE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>331X II</b>		<b>H/O DIABETES MELLITUS</b>			
19A. DATE OF OPERATION <b>7 MAY 68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RELIEF OF ELEV. ICP</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6 MAY 1968</b> to <b>7 MAY 1968</b> , that (I) (we) last saw the deceased alive on <b>7 MAY 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Melvyn L. Tockman M.D.</b>		23B. DATE SIGNED <b>7 MAY 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>Melvyn L. Tockman</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>John A. Moran Inc.</b>		25D. ADDRESS <b>3000 E. Baltimore St.</b>			



BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PHILLIP MEO OR PHILIP F. MEO</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>5 6 68 7:25 a.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 Rear of 4125 Balfern Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 6 1968 7:25 a.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>JAN. 10T. 1910</b>		10. AGE (In years lost birthday) <b>58</b>		E. STREET AND NUMBER <b>117 N. Clinton St.</b>	
11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Carmel MEO</b>	
14A. USUAL OCCUPATION (Give kind of work done during year before death, even if retired) <b>TRUCK KEG MAN</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>BREWERY</b>		15. MOTHER'S MAIDEN NAME <b>Nella Sciacca</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>217-05-11148</b>		18. INFORMANT <b>MRS. SYLVIA MEO</b>	
19. <b>412.2 i</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  <b>443X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Hypertensive arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> <b>May 6, 1968</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY REDEEMER BALTO. Md.</b>	
24D. LOCATION <b>BALTO. Md.</b>		24E. FUNERAL DIRECTOR <b>Frank Della Noce</b>		24F. ADDRESS <b>322 S. HIGH ST.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. ADDRESS <b>322 S. HIGH ST.</b>	

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7:00 PM

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7:00 PM



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4824	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>JAMES M. LINDEMON</b>				5-6-68 5:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MERCY HOSPITAL</b> <b>37</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>A.A.C.</b>	
				C. CITY OR TOWN <b>PASADENA</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>5-30-84</b> 9. AGE (In years last birthday) <b>83</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(Ret)</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>MONTGOMERY WARD</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS LINDEMON</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET NANIMAKER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>215-098292</b>	
17. INFORMANT <b>Augusta A. Lindemon (wife)</b>				ADDRESS	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <b>SPACK, VENTRICULAR</b>	
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF: <b>ARRHYTHMIA</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>MYOCARDIAL INFARCTION</b>	
				DUE TO, OR AS A CONSEQUENCE OF: <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b>	
19. DATE OF OPERATION <b>420.1 II</b>				20A. AUTOPSY? (Yes or No) <b>YES</b>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <b>4-28</b> 19 <b>68</b> to <b>5-6</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5-6</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Samuel A. Torres, M.D.</b>				23B. DATE SIGNED <b>5-6-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>SAMUEL A. TORRES, M.D.</b>				23D. ADDRESS <b>MERCY HOSPITAL, BALTO, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/9/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Woodlawn Maryland</b>		24E. STATE (State) <b>Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Fairburn</b>		25C. FUNERAL DIRECTOR <b>Singleton Funeral Home</b>		25D. ADDRESS <b>Robert Phares</b>	

88 48

(Ref) ~~unpublished~~ ~~ms.~~

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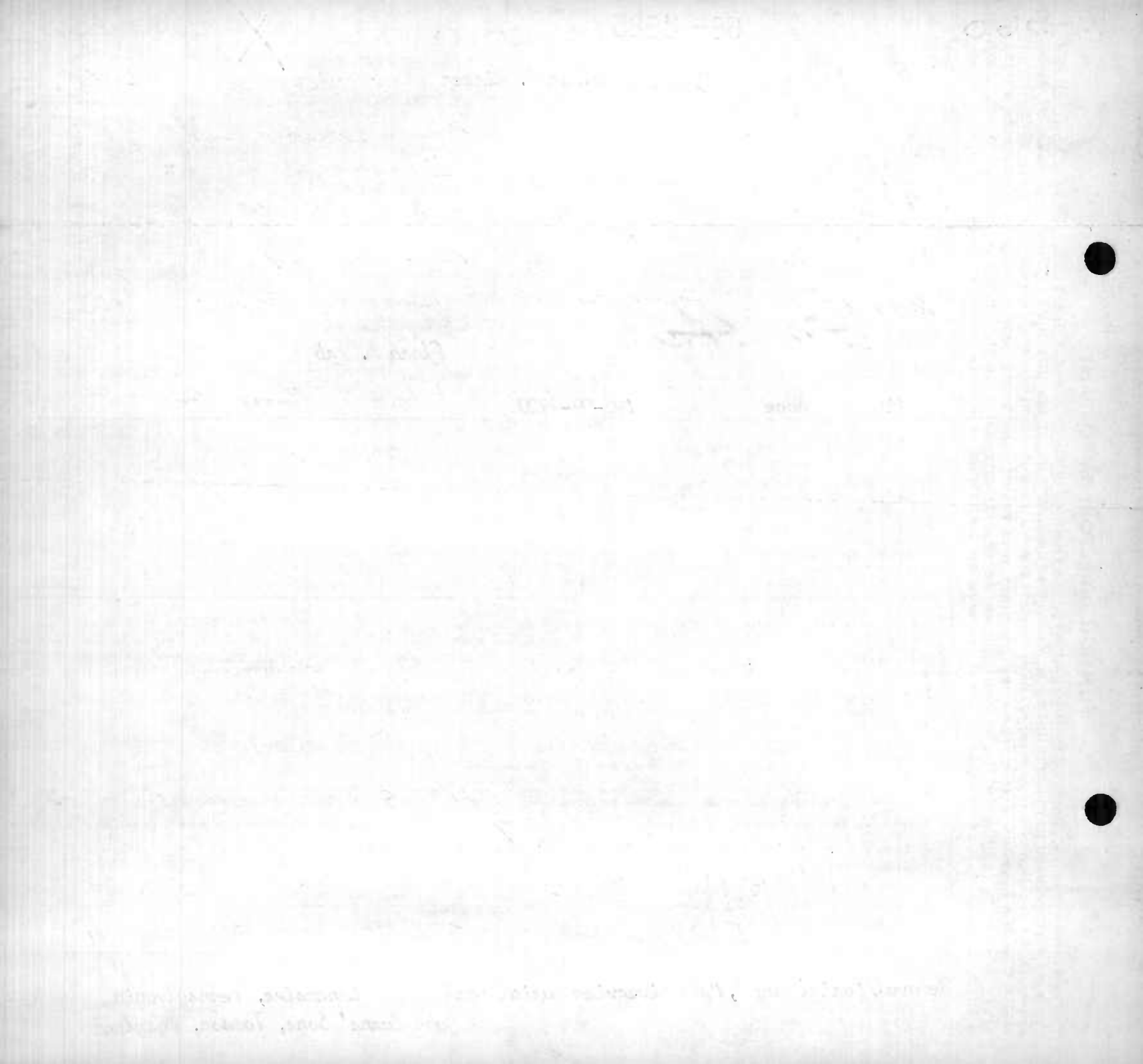
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="border: 1px solid black; padding: 2px;">X</span>	68- 4825
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Rineer, Arthur - Arthur W. Rineer</i>		2. DATE AND HOUR OF DEATH <i>5/7/1968</i> <span style="float: right;"><i>4:45 a.m.</i></span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Penn.</i> B. COUNTY <i>Lancaster - V-35</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital of Baltimore Inc</i> <i>Baltimore Md.</i>			C. CITY OR TOWN <i>Lancaster</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>508 Church St.</i>					
5. SEX <i>M.</i>	6. RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/6/1889</i>	9. AGE (In years lost birthday) <i>69</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Former Bus Driver</i>		11. BIRTHPLACE (State or foreign country) <i>Lancaster Penn</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>Daniel Rineer</i>			14. MOTHER'S MAIDEN NAME <i>Clara M. Erb</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> <i>None</i>		16. SOCIAL SECURITY NO. <i>196-09-9920</i>		17. INFORMANT <i>Robert D. Rineer - Son</i>	
ADDRESS <i>Lancaster Pennsylvania</i>					
18. CAUSE OF DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i>  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>4-20-1</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 6</i> 19 <i>68</i> to <i>May 7</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>May 7</i> 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>I. Meyer Helker</i>			23B. DATE SIGNED <i>5/7/1968</i>		
23C. PHYSICIAN'S NAME (Type) <i>I. Meyer Helker</i>			23D. ADDRESS <i>Sinai Hospital - Baltimore, Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal/Burial</i>		24B. DATE <i>May 9, 1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Riverview Burial Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Lancaster, Pennsylvania</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 8 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>John Burns Sons, Towson, Maryland</i>	



# FUNERAL DIRECTOR: IMPORTANT

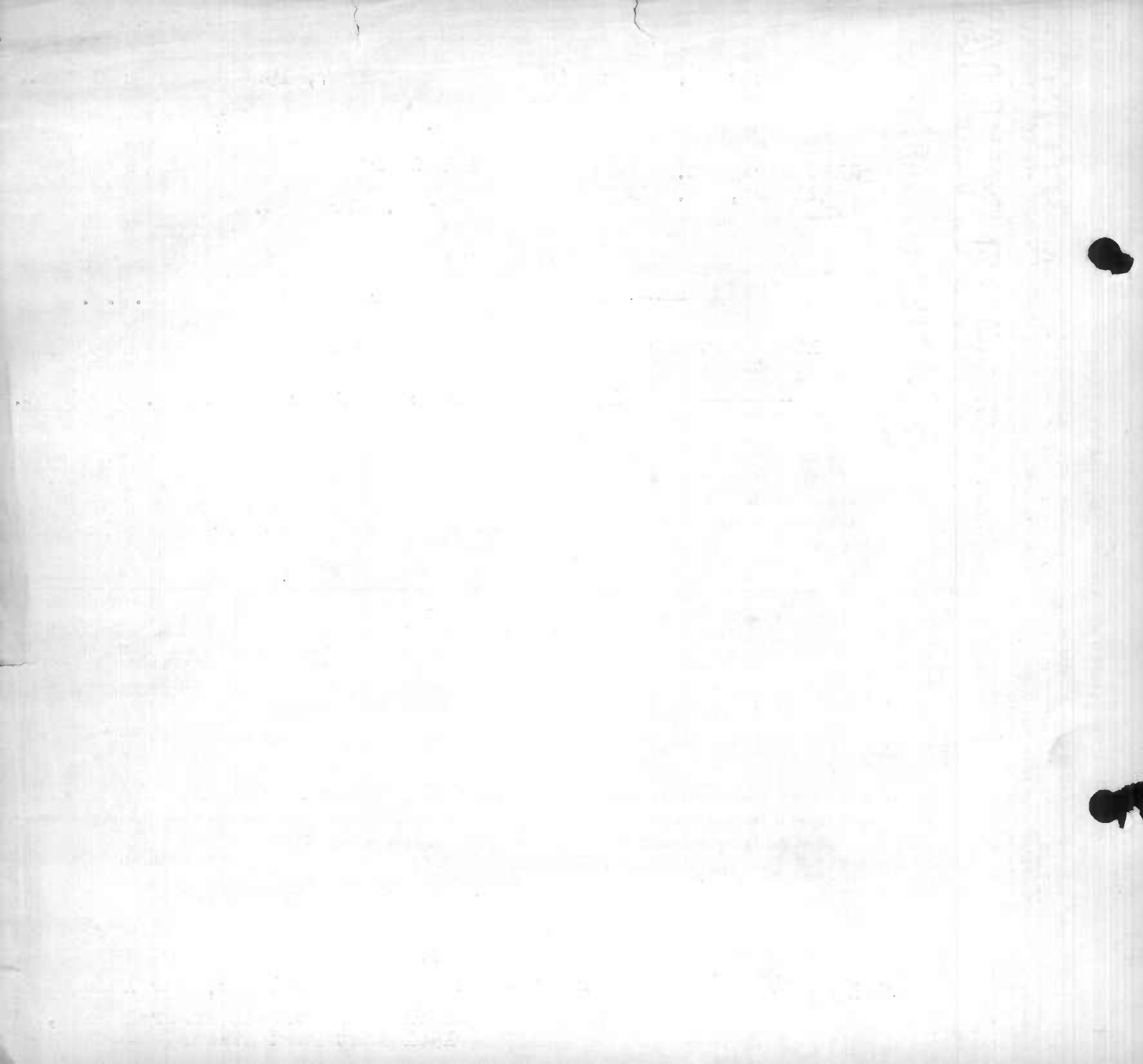
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4826

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-4826

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lottie B. Bulotwic		May 7, 1968 8:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
1116 Carey St. Baltimore, Md. 21230				Maryland	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				1116 S. Carey St.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12/6/98	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Dressmaker		-----		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Julian Bethner			Eva Adams		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-01-5681		Frances McCarroll 1116 S. Carey St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Cerebral Thrombosis				10 days	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
Arteriosclerotic Cardiovascular				2 year	
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) -----					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				2 year	
Fractured right hip					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/27 to 5/7 19 68, that (I) (we) last saw the deceased alive on 5/6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John P. Urlock Jr				5/7/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
John P. Urlock Jr				1227 Washington Blvd	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/10/68		Holy Cross Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 8 1968		Robert E. Jackson		Charles L. Stevens Funeral Home, INC 1501 East Fort Avenue	





F-250

68-4827

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68-4827

BIRTH NO. Fla.

1. NAME OF DECEASED  
(Type or Print)

ANGELA FAISON

2. DATE AND HOUR OF DEATH

4:55 PM 5/4/68

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

Washington, D.C. 71-00

C. CITY OR TOWN

HAWCOCK

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

FOREIGN ORCHARDS

5. SEX

6. RACE

FEMALE NEGRO

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1/3/66

9. AGE (In years  
last birthday)

2

If Under 1 Yr. If Under 24 Hrs.  
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

N.A.

10B. KIND OF BUSINESS OR INDUSTRY

N.A.

11. BIRTHPLACE (State or foreign country)

?

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

3. FATHER'S NAME

BINON FAISON

14. MOTHER'S MAIDEN NAME

ALICE

5. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

NA

17. INFORMANT

ADDRESS

18.

788.6 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ACIDOSIS (METABOLIC)

16 hrs.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Colon Bypass Procedure

(C)

Lye ingestion (

6 Months

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)

19A. DATE OF OPERATION

5/2/68

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

Lye Stricture of Esophagus

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

VA. Virginia

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
Oct. 24, 1967

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR?

Ingested Lye

22. I certify that (I) (this hospital) attended the deceased from 10/27 19 67 to 5/4 19 68, that (II) (we) lost saw the deceased alive on 5/4 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

F. J. Scarpa, M.D.

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5/4/68

23C. PHYSICIAN'S  
NAME (Type)

F J SCARPA MD

23D. ADDRESS

JOHNS HOPKINS MEDICAL SCHOOL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

5-7-68

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAY 8 1968

F. J. Scarpa, M.D.

HOSPITAL DISPOSAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RELEASED ON APPROVAL OF: MEDICAL CERTIFICATION DR. KORNBLUM (KORNBLUM)



John King

Blue Train

Female Photo

W.A.

Price

1/2/10

Color Photos

Academy (University)

The Institute

The Institute of Science

Out of the

the Institute of Science

the Institute of Science

2/10

2/10

2/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">68-4828</span>
BIRTH NO. <span style="font-size: 1.2em;">68-04631 ? 68-4828</span>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Willaims, B. O. Mamie</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">3-12-68</span> <span style="float: right;">12:30 p. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em; float: left; margin-right: 5px;">39</span> <span style="float: right;">Provident Hospital 1514 Division Street Baltimore, Maryland</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em; float: right;">13-83</span> C. CITY OR TOWN <span style="font-size: 1.1em;">Baltimore</span> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.1em;">2414 Francis Street</span>		
5. SEX <span style="font-size: 1.1em;">Male</span>	6. RACE <span style="font-size: 1.1em;">Negro</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.1em;">3-12-68</span>	9. AGE (In years last birthday) <span style="font-size: 1.1em;">4</span> <span style="float: right;">9</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Unemployed</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Maryland</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">U. S. A.</span>		13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Mamie Williams</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. <span style="font-size: 1.5em;">776.9 I</span> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Atelectasis - neonatorum</span> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Prematurity.</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">6 hrs.</span>				
19. <span style="font-size: 1.5em;">762.5 II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">3-12-68</span> 19 to <span style="font-size: 1.1em;">3-12-68</span> 19, that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">3-12-68</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.2em;">P. SETASUBAN M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">3-12-68</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">P. SETASUBAN M.D.</span>
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">5-8-68</span>		
24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 8 1968</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Bailey</span>		25C. FUNERAL DIRECTOR ADDRESS

ANATOMY BOARD OF MARYLAND  
JOHNS HOPKINS MEDICAL SCHOOL  
MORTUARY SERVICE - BOND

85-22

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
68- 4829				68- 4829	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Jacob Hunsberger.		4/29/68 12 <sup>05</sup> A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp.			A. STATE Maryland 4 21230. B. COUNTY C. CITY OR TOWN Baltimore 23-2 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 929 S. Charles St.		
5. SEX M	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-1886	9. AGE (In years last birthday) 82	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
			11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure 4 MO (B) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE (C) SEA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II SENILITY					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>my</del> (this hospital) attended the deceased from 4/26 1968 to 4/29 1968, that <del>we</del> (we) last saw the deceased alive on 4/29 1968 and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas H. Emory M.D.				23B. DATE SIGNED 4/29/68	
23C. PHYSICIAN'S NAME (Type) Thomas H. Emory M.D.				23D. ADDRESS 536 N. E. BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5-7-68		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR Robert E. Taylor		24F. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD	
25A. DATE REC'D. BY HEALTH DEPT. MAY 8 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
68- 4830				68- 4830	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>WILHELM F. KAISER</b>			2. DATE AND HOUR OF DEATH <b>APRIL 24, 1968 6:12 AM.</b>		
3. PLACE IN <b>BALTIMORE, MARYLAND</b> , WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (If institution: State and before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALT.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>657 1/2 W. LEXINGTON STREET</b>		
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/1/03</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
18. <b>162.1 I</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRONCHOGENIC CARCINOMA</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C).....			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
18. <b>162.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>PULMONARY EMPHYSEMA</b> <b>UNKNOWN</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 23 1968</b> to <b>APRIL 24 1968</b> , that (I) (we) last saw the deceased alive on <b>APRIL 23 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ronica M. Kluge, M.D.</b>				23B. DATE SIGNED <b>APRIL 24, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>RONICA M. KLUGE, M.D.</b>				23D. ADDRESS <b>UNIV. HOSPITAL BALT. MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>5-2-68</b>		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS <b>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL HOSPITAL DISPOSAL</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>		25C. FUNERAL DIRECTOR ADDRESS	

2508



Body released by Anthony Boud  
 FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4831

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-4831

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ALBERT CLARK</b>		2. DATE AND HOUR OF DEATH <b>4/30/68 6 20 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSP.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>5/9/16</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		9. AGE (In years last birthday) <b>51</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>	
17. INFORMANT <b>MR. WILLIAM L. CLARK</b>		ADDRESS <b>6621 HARR-FORD ROAD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <b>LUNG TUBERCULOSIS</b> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <b>A leishmaniasis</b> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <b>300</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>002.1 II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>this hospital</b> attended the deceased from <b>April 26 1968</b> to <b>April 30 1968</b> , that (I) <b>we</b> last saw the deceased alive on <b>April 30 1968</b> and that in (my) <b>an</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>we</b> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Enrique Cipriani M.D.</b>				23B. DATE SIGNED <b>4/30/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>ENRIQUE CIPRIANI MD.</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>5-6-68</b>				24B. DATE	
24C. NAME OF CEMETERY or CREMATORY <b>ANATOLIAN</b>				24D. LOCATION (City, town, or county) <b>BALTIMORE</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
25C. FUNERAL DIRECTOR				ADDRESS <b>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>	

X

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MEMORANDUM FOR THE DIRECTOR

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MR. WILLIAM L. BROWN

LUNG TUBERCULOSIS

A. L. BROWN

April 30, 1910

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FRAIGUE, E. J. M. 23 and 24

2-1-10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-4001		68-- 4832		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-- 4832		4	
BIRTH NO. 68-07646		CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) Baby Boy BEALL		2. DATE AND HOUR OF DEATH April 27, 1968 14:45 A M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY				53-00			
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL 3324 CALVERT ST. 44 Baltimore, MARYLAND		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/26/68		9. AGE (In years lost birthday) 1 day	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES BEALL		14. MOTHER'S MAIDEN NAME MARY E. LEHMAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. JAMES BEALL	
18. 774.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE				ADDRESS 1515 Dogbury Road BALTIMORE, MARYLAND			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ANEMIA		(B) ANEMIA DUE TO, OR AS A CONSEQUENCE OF: ANEMIA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 weeks			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 770.0 II		(C) ERYTHROBLASTOSIS FETALIS				11 weeks			
19A. DATE OF OPERATION 4/26/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ANEMIA - EXCHANGE TRANSFUSION		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from April 26 1968 to April 27 1968, that (we) last saw the deceased alive on April 27, 1968 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.									
23A. SIGNATURE William H. Spencer - Strong M.D.		23B. DATE SIGNED April 27, 1968		23C. PHYSICIAN'S NAME (Type) WILLIAM H. SPENCER - STRONG M.D.		23D. ADDRESS UNION MEMORIAL HOSPITAL BALTIMORE, MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) 5-2-68		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAY 8 1968		25B. NAME OF REGISTRAR Ruth E. Taylor		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL		25D. ADDRESS MORTUARY SERVICE - BCHD			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

68- 4833

BIRTH NO. 6807599

1. NAME OF DECEASED

(Type or Print)

BOB BOY PRINCE

2. DATE AND HOUR OF DEATH

4/24/68 6:20 P.M.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY OF MARYLAND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

2042 LINDEN AVE - MD. -

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

BALTIMORE

YES ☒ NO ☐

E. STREET AND NUMBER

SAME AS ABOVE

5. SEX

M

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

4/24/68

9. AGE (In years last birthday)

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

2 18

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

INFANT

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

FRANCES PRINCE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

PATIENT'S CHART

18. 777X I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

PREMATURITY

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

776X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 24 1968 to April 24 1968, that (I) (we) last saw the deceased alive on April 24 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Esther E. Dery, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4/24/68

23C. PHYSICIAN'S NAME (Type)

ESTHER EDERY, M.D.

23D. ADDRESS

UNIVERSITY MEDICAL SCHOOL

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

5-2-68

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

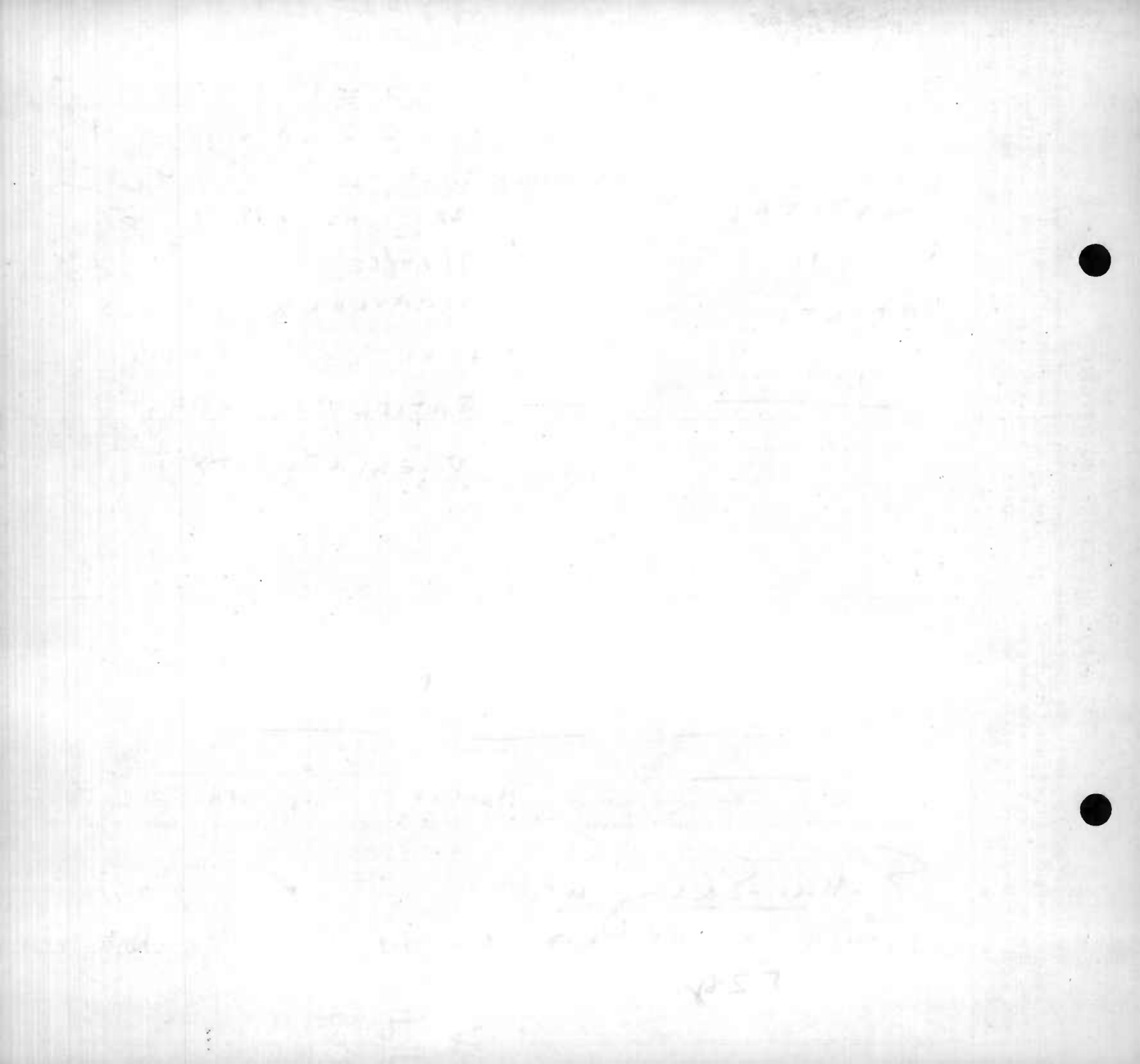
25C. FUNERAL DIRECTOR

ADDRESS

MAY 8 1968

Robert E. Fairbanks

HOSPITAL DISPOSAL



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-07892		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4834
1. NAME OF DECEASED (Type or Print) JONES BABY BOY		2. DATE AND HOUR OF DEATH 4/28/68 4 45 pm M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4/6 LUTHERAN HOSPITAL,		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? 16-07 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3030 Belmont Ave.		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/68	9. AGE (In years last birthday) 9 17 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Jesse Hoos, Jr.		
14. MOTHER'S MAIDEN NAME DELORES GRAY.		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT Chart		
18. 772.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrest 9 hrs 17 mins (B) Possible Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. 760.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No) D	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4/28 1968 to 4/28 1968, that (I) (we) last saw the deceased alive on 4/28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE S. J. Noble MD		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) S. J. NOBLE
23D. ADDRESS Lutheran Hospital } Baltimore 730 Belmont St ANATOMICAL BOARD OF MARYLAND		23E. UNIVERSITY MEDICAL SCHOOL ADDRESS		
24A. BURIAL CREMATION REMOVAL (Specify) 5-2-68	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		
25A. DATE REC'D BY HEALTH DEPT. MAY 8 1968	25B. NAME OF REGISTRAR R. E. F. F.	25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		



005-8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 4835 CERTIFICATE OF DEATH

REG. NO. 68- 4835

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PITT, HENRIETTA P.</b>		2. DATE AND HOUR OF DEATH <b>5/8/68</b>		4 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTIMORE CITY</b>	
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
				E. STREET AND NUMBER <b>613 BARTLETT AVENUE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-24-30</b>		9. AGE (In years lost birthday) <b>37 yrs</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>	
13. FATHER'S NAME <b>Alonza Slaysman</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Southcomb</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>21803 53310</b>		17. INFORMANT <b>SON - WILLIAM PITT</b>		ADDRESS <b>SAME AS DECEASED</b>	
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>DIABETES MELLITUS</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>URINARY TRACT INFECTION</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>SEMILITY 7 A.S.C.V.D.</b> (C) <b>260X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <b>4/23/68</b> to <b>5/8/68</b> , that (I) (we) last saw the deceased alive on <b>5/7/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dermot Campbell M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/8/68.</b>	
25C. PHYSICIAN'S NAME (Type) <b>DERMOT CAMPBELL MD</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>5/11/68.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
				24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Balto. Md. 21214</b>	

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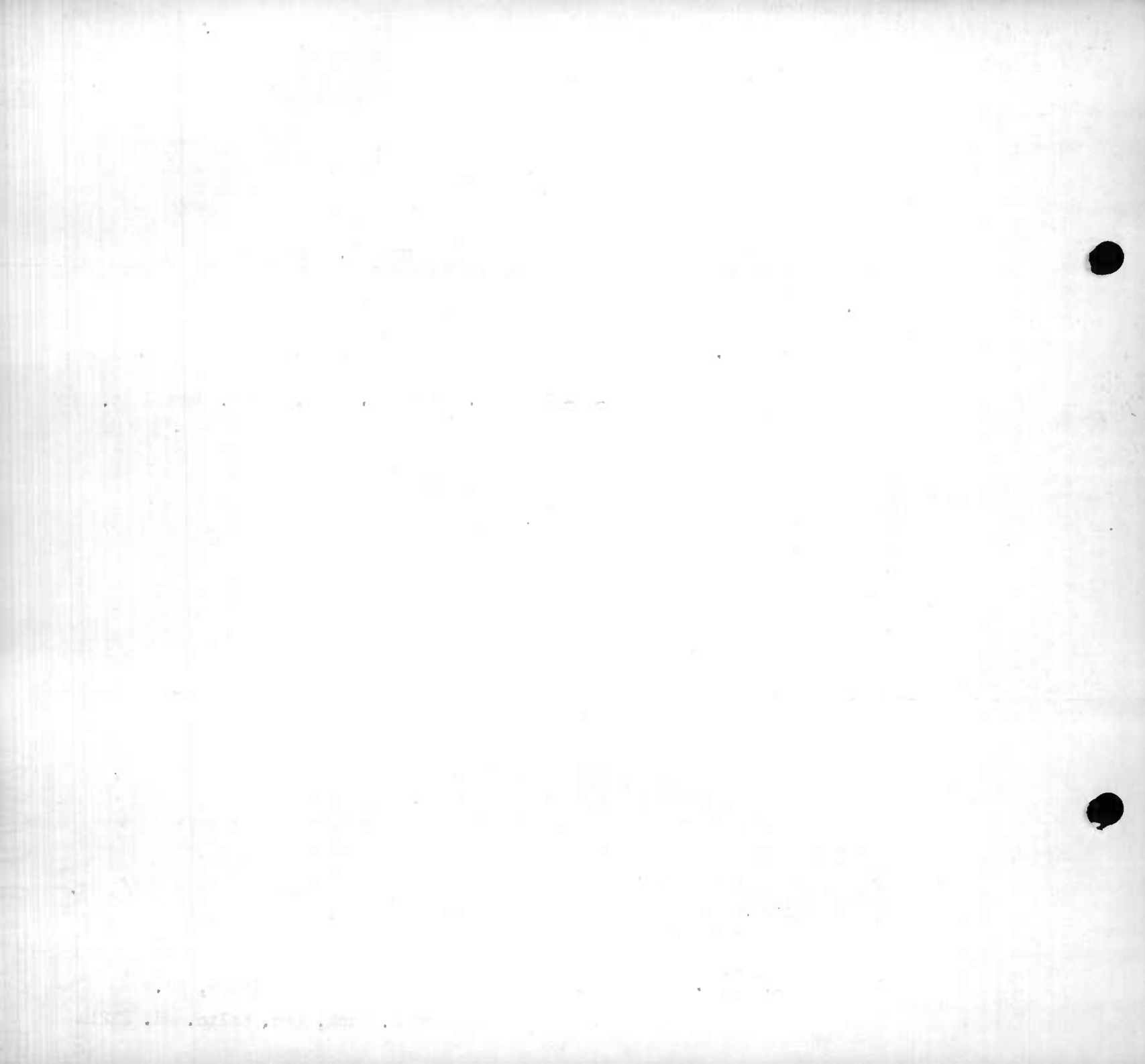
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4836 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68-4836

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MR. Frederick HERBERT Jr.</b>		2. DATE AND HOUR OF DEATH <b>5/7/68 8:50 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48th General Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Hotel Alcazar 712 Cathedral Street</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/83</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unk.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md. Annapolis</b>	
13. FATHER'S NAME <b>FREDERICK G. HERBERT</b>			14. MOTHER'S MAIDEN NAME <b>Agnes Eichelmann</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-1356</b>		17. INFORMANT ADDRESS <b>Mr. Robert C. Prem, 929 N. Howard St. 21201</b>	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic</b></p> <p>(B) <b>Carcinoma bladder</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>					
187.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/5/1968</b> to <b>5/7/1968</b> , that (I) (we) last saw the deceased alive on <b>5/7/1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. Swarup</b>				23B. DATE SIGNED <b>5/7/68.</b>	
23C. PHYSICIAN'S NAME (Type) <b>S. SWARUP</b>		23D. ADDRESS <b>48th Gen. Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/68.</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Feltner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21211</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4837

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 4837

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>FORSTER, THEODORE</b>		2. DATE AND HOUR OF DEATH <b>5-6-68 8:00 PM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore Co</b>		5. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>104 PARK DRIVE 21228</b>	
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-15-90</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Paint Distributor</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>FORSTER, Isaac S.</b>		14. MOTHER'S MAIDEN NAME <b>VIOLA YOUNG</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-2896A</b>		17. INFORMANT <b>Mrs. Elise Forster</b>	
ADDRESS <b>(Same)</b>		18. <b>450X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Dr. Yen</b>			
19. <b>465X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-11-1968</b> to <b>5-6-1968</b> , that (I) (we) last saw the deceased alive on <b>5-6-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Raul V. Desquitado</b>		DEGREE		23B. DATE SIGNED <b>5-6-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>RAUL V. DESQUITADO</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL UNION MEMORIAL HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>5/8/68.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Crematory</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Baltimore, Md. 21214</b>	
ADDRESS					

DATE: 1951 JAN 17



B-640

68- 4838

BALTIMORE CITY HEALTH DEPARTMENT

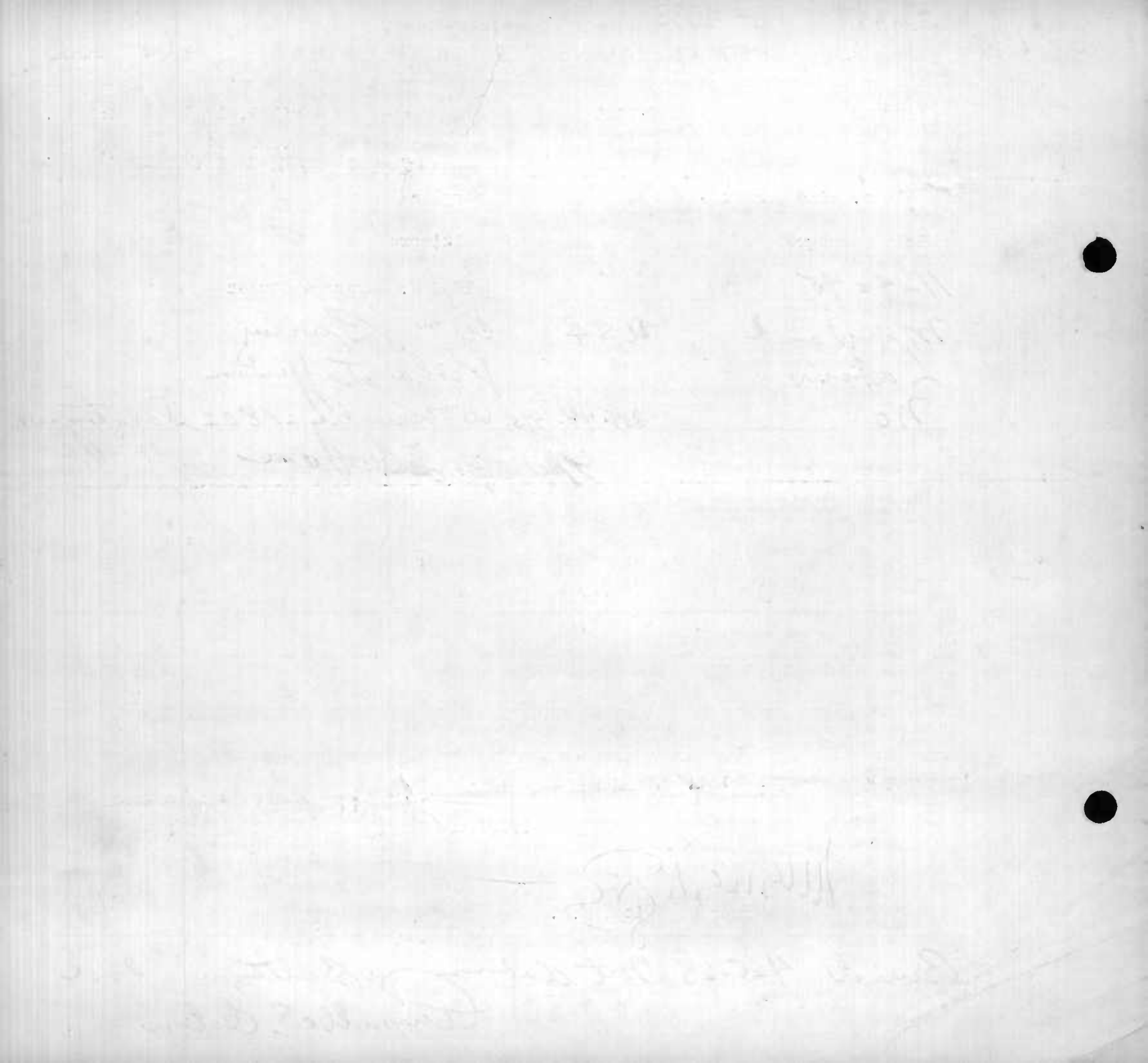
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4838

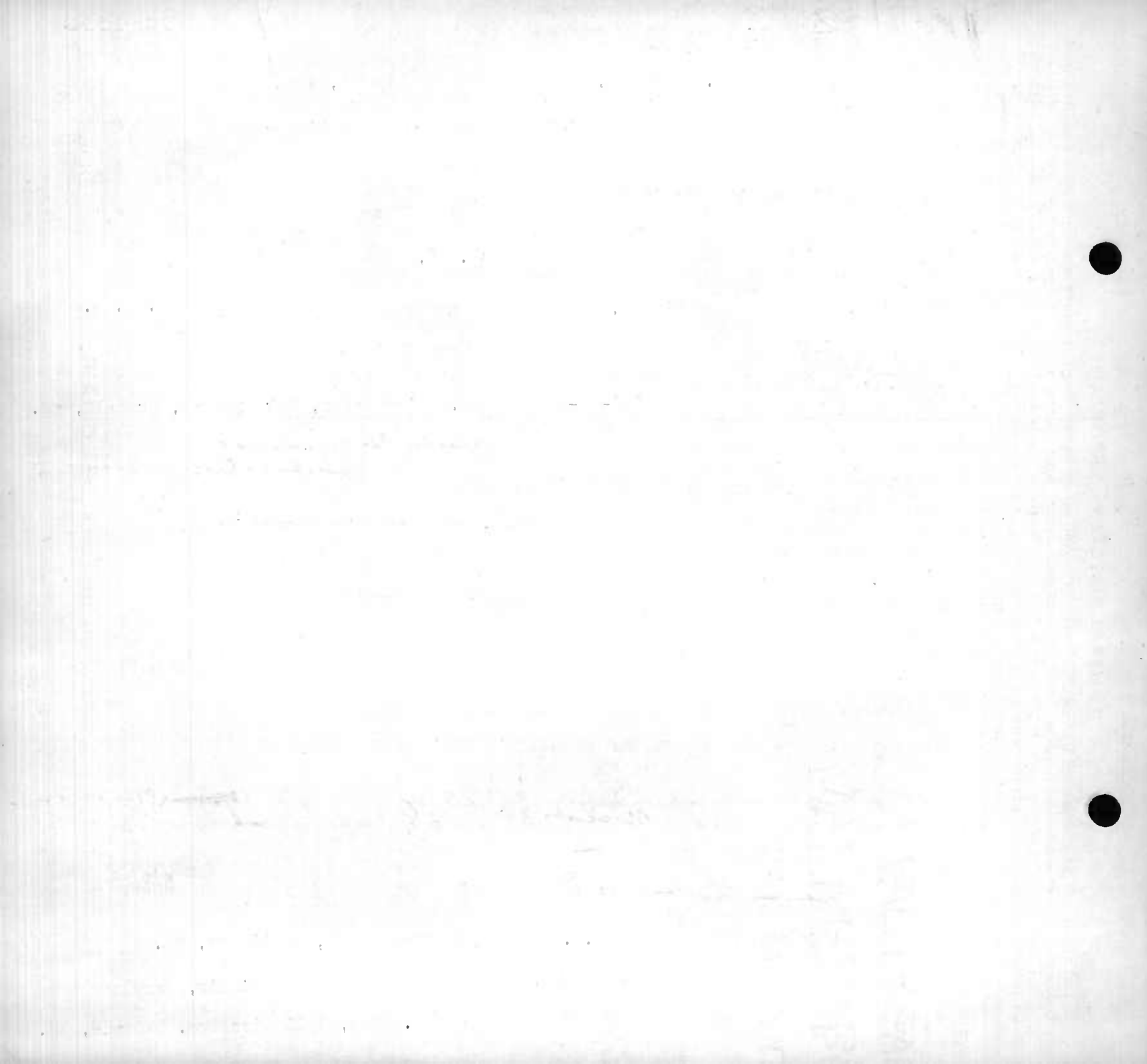
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ANGELO BURLEY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>April 1, 1968 4:20 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>416 N. Pine Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 1, 1968 4:20 A.M.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>11-4-45</b>		10. AGE (In years last birthday) <b>22</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm Burley</b>		14. MOTHER'S MAIDEN NAME <b>Viola Jefferson</b>	
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-01</b>		E. STREET AND NUMBER <b>1802 W. Saratoga Street</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-44-3475</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Narcotic Overdose</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>304.9 I</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>323X II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>4/1/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>4-5-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>Turnell B. Oden</b>		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4839</b>
<b>K-632</b> <b>BIRTH NO.</b> <b>68-4839</b>		<b>CERTIFICATE OF DEATH</b>		
<b>1. NAME OF DECEASED</b> (Type or Print) <b>George L. Kratz Sr.</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>May 6, 1968</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospital (DOA)</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>B. COUNTY</b> <b>Maryland Baltimore Co</b>		
<b>5. SEX</b> <b>Male</b>		<b>6. RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>
<b>8. DATE OF BIRTH</b> <b>Feb. 22, 1904</b>		<b>9. AGE</b> (In years last birthday) <b>64</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Tool Maker</b>
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		
<b>13. FATHER'S NAME</b> <b>John Kratz</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Shriner</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>215-09-1010</b>		<b>17. INFORMANT</b> (Wife) <b>Mrs. Alice Kratz, 2470 Keyway, Dundalk, Md.</b>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>410.9 I</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>acute myocardial infarction</b> <b>Anteroseptal heart disease</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>Several</b>		
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>420.1 II</b>		<b>20. AUTOPSY?</b> (Yes or No) <b>No</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>19.5.2</b> <b>19</b> <b>to</b> <b>March 30 1968</b> <b>that (I) (we) lost saw the deceased alive on</b> <b>March 30 1968</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>		<b>23A. SIGNATURE</b> <b>Lester Lebo M.D.</b>		
<b>23B. DATE SIGNED</b> <b>5/7/68</b>		<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Lester Lebo M.D.</b>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>5/9/68</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Bel Air Memorial Gardens</b>
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Bel Air, Maryland</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 9 1968</b>		
<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor</b>		<b>25C. FUNERAL DIRECTOR</b> <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		



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K-400

68- 4840 BALTIMORE CITY HEALTH DEPARTMENT

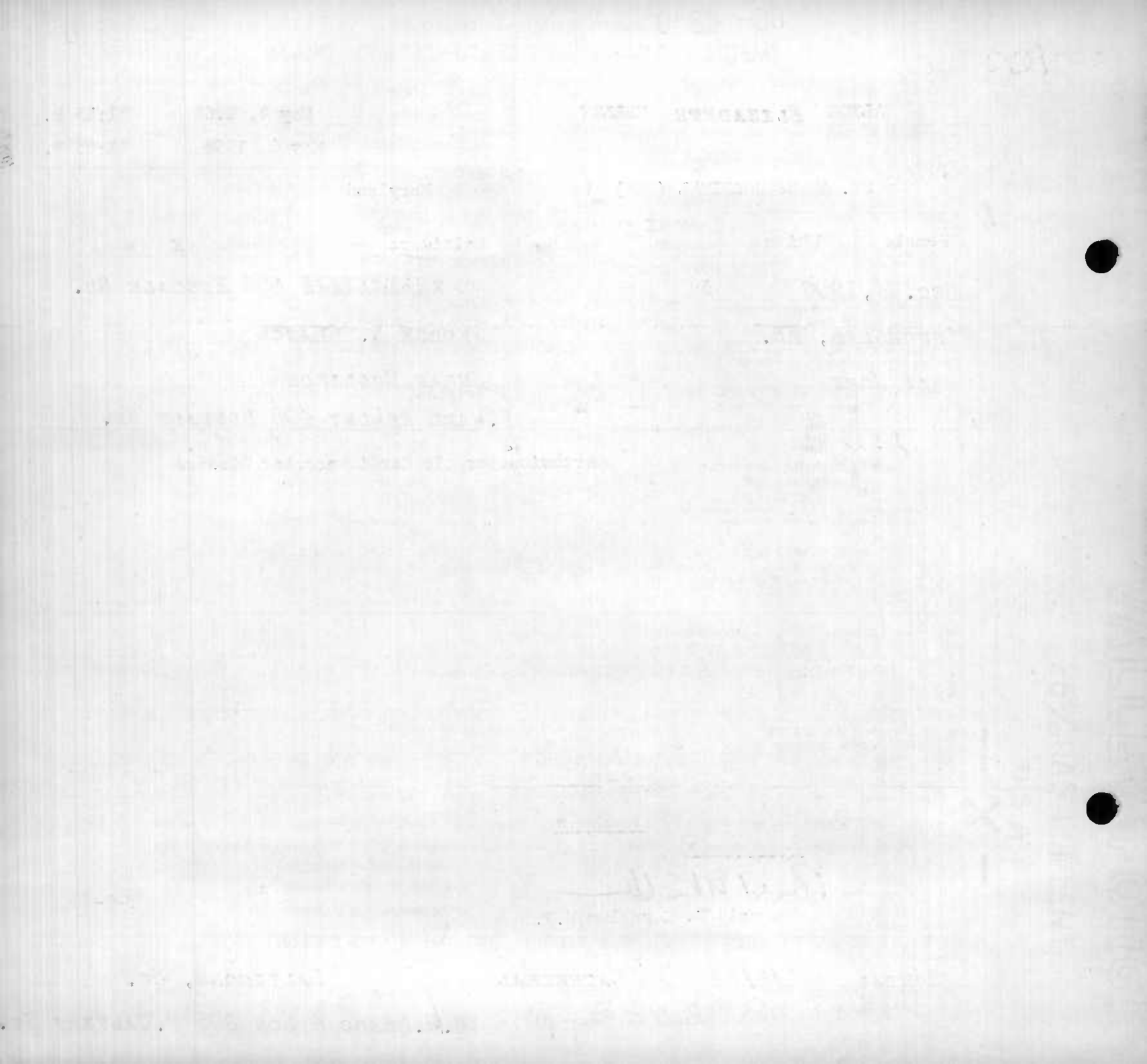
68- 4840

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ALICE ELIZABETH KELLEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 4, 1968</b> <b>11:15 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 4, 1968</b> <b>11:15 P.M.</b>	
6. SEX <b>Female</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>White</b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>DEC. 24, 1908</b>		10. AGE (In years last birthday) <b>59</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>ANNAPOLIS, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME <b>GEORGE R. CHANCE</b>		15. MOTHER'S MAIDEN NAME <b>SUSAN COLLISON</b>	
18. INFORMANT <b>F. WARD KELLEY</b>		ADDRESS <b>405 EDS DALE RD.</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION <b>422.1</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>	
21. AUTOPSY? (Yes or No) <b>no</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> EXAMINER'S NAME (Type)		M.D. <b>Ronald N. Kornblum, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/8/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>CATHEDRAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
25C. FUNERAL DIRECTOR <b>H.W. MEARS &amp; SON</b>		ADDRESS <b>805 N. CALVERT ST.</b>	

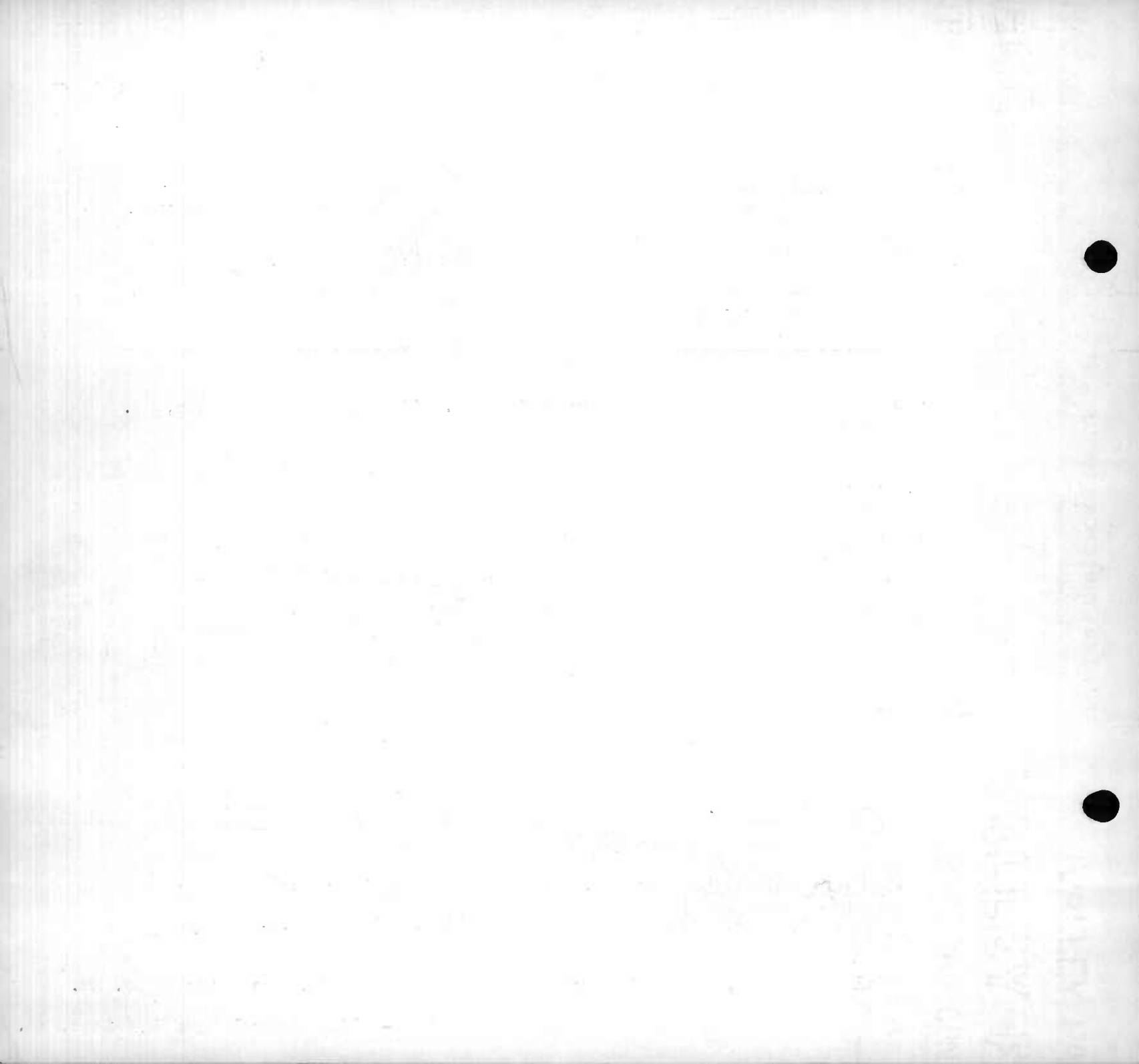


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Emory C. Zepp		5/7/68 4:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Maryland Gen. Hosp.			Md. Balt. Co. 53-00		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Garrison		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			Comm. Nursing Home (Foxleigh)		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
♂	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3/14/90	78	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
State Road Employee			Maryland		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Jacob Zepp			Sarah Kerchner		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no			212 14 9291		Mrs. Milton Alban Manchester, Md.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Pneumonia		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) Anemia, DM, CHF, ASCVD		
293X II			Dehydration		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Disinfectant's colostomy		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/2/68 19 to 5/7/68 19					
that (I) (we) last saw the deceased alive on 5/7/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ralph D. Raymond MD				5/7/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Ralph D. REYMOND				Maryland Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		May 9, 1968		Lineboro Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Lineboro Carroll Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 9 1968		Ralph E. Farber		Tipton - Eline Funeral Home Hampstead, Md.	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-4842

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN PAUL KEINER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 6, 1968</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 6, 1968</b> 7:40 P.M.	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>June 29, 1916</b>		10. AGE (In years lost birthday) <b>51</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assembler Royals Mfg. Co.</b>		15. MOTHER'S MAIDEN NAME <b>Alice Roberts</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes Army WW 2</b>		17. SOCIAL SECURITY NO. <b>215-10-6406</b>	
18. INFORMANT <b>Emlyn Bartlett Keiner, wife, above</b>		ADDRESS	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. <b>422.1</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>5/7/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Transit-Burial</b>		24B. DATE <b>5/10/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Odd Fellows Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Clarksburg, W. Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>	

WALTER POLICE

WALTER POLICE

WALTER POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4843

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4843

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Brown Mr. Quincy R.</b>		2. DATE AND HOUR OF DEATH <b>5-3-68 7:35 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore Co</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 Church Home &amp; Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>3916 OLD NORTH PT RD.</b>		8. DATE OF BIRTH <b>4-5-03</b>		9. AGE (In years last birthday) <b>65</b>	
S. SEX <b>Male</b> 6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk O'Sullivan Rubber Co.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>DOK BROWN</b>		14. MOTHER'S MAIDEN NAME <b>MAGGIE CLUTTER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-22-5065</b>		17. INFORMANT (Sister) <b>Dundalk, Md. 21222</b> <b>Mrs. Hallie Hamrick, 3916 Old North Pt. Rd.</b>	
18. <b>492X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>HEAR FAILURE 12 years</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>CHR. EMPHYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
527.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-1-1968</b> to <b>5-3-1968</b> , that (I) (we) last saw the deceased alive on <b>5-3-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>L. Kirley MD.</b>				23B. DATE SIGNED <b>5-3-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>L. Kirley MD.</b>				23D. ADDRESS <b>Church Home &amp; Hospital, Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Ellis Chapel Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Brushy Flat, West Virginia</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>John J. Duda, Dundalk, Maryland 21222</b>		25D. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-4844		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-4844	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) EMILE JAMES ALBERT		
2. DATE AND HOUR OF DEATH MAY 6, 1968 6:30 A.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION 44 THE UNION MEMORIAL HOSPITAL 3300 CALVERT STS BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) THE ALCAZAR HOTEL			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 5-14-06	9. AGE (In years last birthday) 61	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
11. BIRTHPLACE (State or foreign country) HUNGARY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSEPH ALBERT			14. MOTHER'S MAIDEN NAME ADELE SARTORIUS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES World War II		16. SOCIAL SECURITY NO. 215-01-8869		17. INFORMANT JOSEPH ALBERT (brother) 8310 Northway Ave Baltimore, Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. MULTIPLE MYOCARDIAL INFARCTIONS IN PAST EPISODES OF CONGESTIVE HEART FAILURE		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO CORONARY ATHEROSCLEROSIS (B) <del>CORONARY ATHEROSCLEROSIS</del> DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 5 days 12 years			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from MAY 1 1968 to MAY 6 1968, that (we) lost saw the deceased alive on MAY 6 1968 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.					
23A. SIGNATURE William H. Spencer-Stang			23B. DATE SIGNED MAY 6, 1968		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS Union Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-9-68		24C. NAME OF CEMETERY or CREMATORY BALTO NATIONAL	
24D. LOCATION BALTO - Md.		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Fodora	
25C. FUNERAL DIRECTOR		25D. ADDRESS 1300 East Ave			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 4845 CERTIFICATE OF DEATH

68- 4845  
REG. NO. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HATTIE MURPHY</b>		2. DATE AND HOUR OF DEATH <b>5- 3- 68</b> <b>9</b> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY _____		
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MD.</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2922 ARUNAH AVE</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9- 17- 84</b>	9. AGE (In years lost birthday) <b>83</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laundress</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Ray</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-4591-D</b>		17. INFORMANT <b>CHART</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Progressive Cerebral Thrombosis</b> <b>Cerebral arteriosclerosis</b> <b>Hypertension</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>332X II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4- 26</b> 19 <b>68</b> to <b>5- 3</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5- 3</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. Aziz M.D.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>S. AZIZ M.D.</b>				23D. ADDRESS <b>LUTHERAN HOSPITAL OF MD. BALTIMORE MD 21216</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/9/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>4/27 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Walters Funeral Home</b>	
				ADDRESS <b>Pratt &amp; Stricker Sts.</b>	

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Reference Chart

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
BOHN, CARL VINCENT JR.		MAY 7, 1968 12:00 P.M.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		C. CITY OR TOWN INSIDE CITY LIMITS?	
ST AGNES HOSPITAL		MARYLAND BALTIMORE 21227		YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		F. STREET AND NUMBER		G. STREET AND NUMBER	
1115 PLOVER DRIVE		1115 PLOVER DRIVE		1115 PLOVER DRIVE	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birth day)	10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	07/31/19	48	Salesman
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Salesman		Ihrrie Potato Chip Co.		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
CARL VINCENT BOHN SR.		Margaret Owens		U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		216072951		ST AGNES RECORDS-WILKENS & CATON AVES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CIRCULATORY COLLAPSE			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		ACUTE HEMORRAGE (INTRAABDOMINAL)			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		SPONTANEOUS RUPTURE-SPLEEN			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
298.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		HISTORY OF PULMONARY EMBOLISM.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21		YES	YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (X) (this hospital) attended the deceased from APRIL 27, 19 68 to MAY 7, 19 68, that (X) (we) last saw the deceased alive on MAY 7, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
ALEJANDRO MEDIA. MD.				May 17/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ALEJANDRO MEDIA.		ST AGNES HOSPITAL CATON & WILKENS AVE BALTIMORE, MARYLAND 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	5-11-1968	Loudon Park Cemetery	Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
MAY 9 1968	Robert E. Finkbeiner	Howard H. Hubbard, 4107 Wilkens Ave.		21229	

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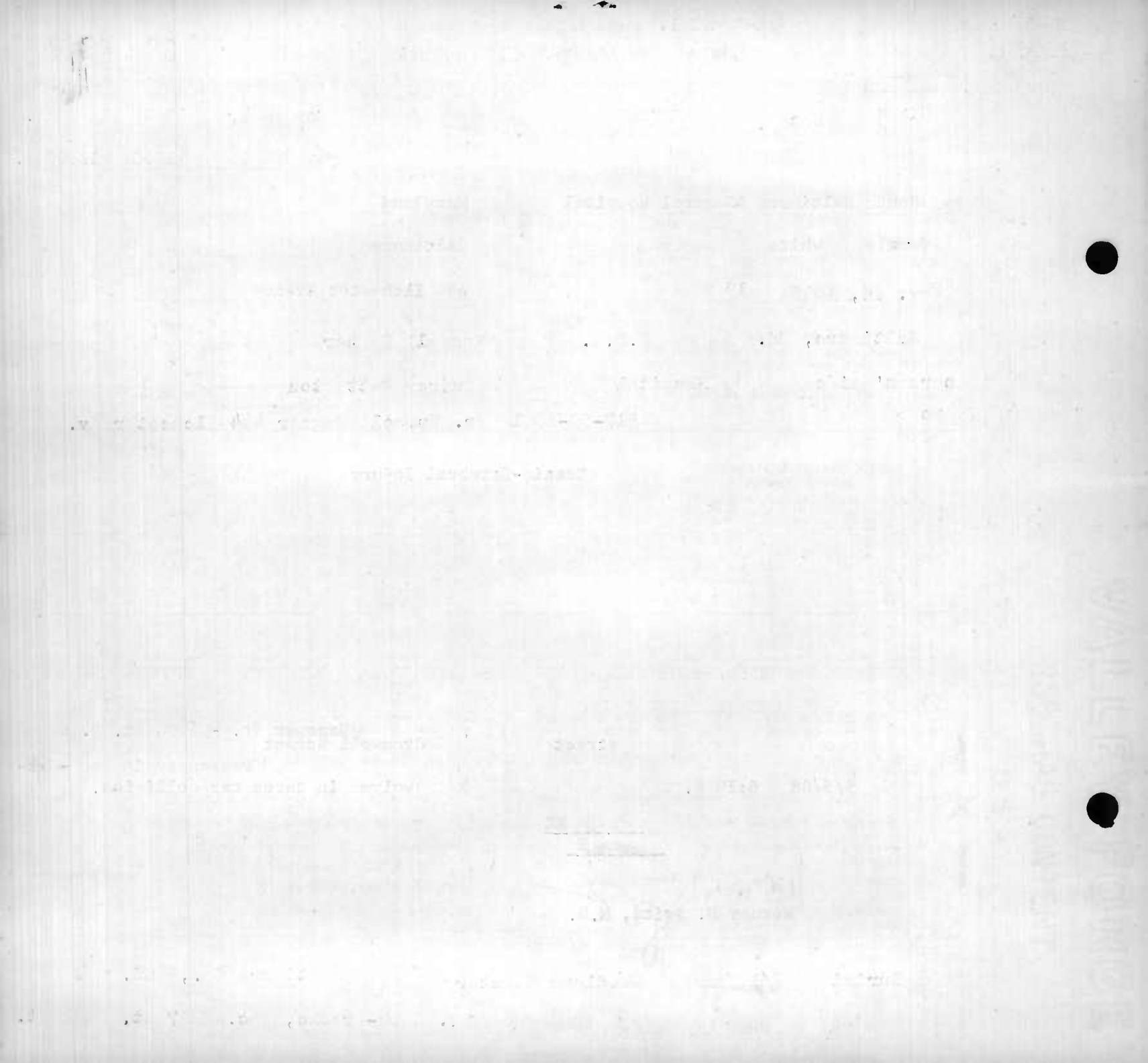
68-4847 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-4847

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DIANE Rae HAGNER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>May 7, 1968 12:00 A.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 7, 1968 12:00 A.</b>	
6. SEX <b>female</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>white</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Nov. 28, 1948</b>		10. AGE (In years lost birthday) <b>19</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>nurses' aide</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>217-50-2081</b>	
18. INFORMANT <b>Audrey Catterton</b>		ADDRESS <b>Mr. Russell Hagner 444 Ilchester Av.</b>	
19. <b>E 81211</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cranio-Cerebral Injury</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>5/7/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22D. TIME OF INJURY (APPROX.) <b>5/5/68 6:10 P. m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Hanover St. - 1084 ft. S. of Cromwell Street</b>		22F. HOW DID INJURY OCCUR? <b>Passenger in car - involved in three car collision.</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type)  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>5/7/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc.</b>		ADDRESS <b>1217 St. Paul St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				REG. NO. 68-4848	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>James P. Leary</i>		2. DATE AND HOUR OF DEATH <i>5-8-68</i> <i>12</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>md</i> B. COUNTY		5. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 Unw. Hosp</i>		E. STREET AND NUMBER <i>920 W. Balto St</i>			
5. SEX <i>m</i>	6. RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/10/81</i>	9. AGE (In years last birthday) <i>86</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>machinist</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Balmar Corp.</i>		11. BIRTHPLACE (State or foreign country) <i>Ireland</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>218-01-3464A</i>		17. INFORMANT <i>Mr Francis Leary</i> ADDRESS <i>2820 Maudlin Ave</i>	
18. <i>7-12-4</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i> <i>C. V. A.</i> <i>ASGVO</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>DAYS</i> <i>years</i> <i>years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>422.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/6/68</i> 19 to <i>5/8</i> 1968, that (I) (we) last saw the deceased alive on <i>5/8</i> 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Michael Kaliner MD</i>		23B. DATE SIGNED <i>5-8-68</i>		23C. PHYSICIAN'S NAME (Type) <i>Michael Kaliner</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/10/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cem.</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. STATE <i>md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 9 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>		25C. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son Inc.</i>		25D. ADDRESS <i>987 Hollis St. Balt. Md.</i>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		68- 4849	
C-253		68- 4849	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
HELEN COSENTINO		5-7-68 2:40 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CERTIFICATE AMENDED</b> <b>THE JOHNS HOPKINS HOSPITAL 2-9-72</b> <b>33</b>		A. STATE MARYLAND	
		B. COUNTY Baltimore	
5. SEX FEMALE		6. RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 2-10-24	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 44	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MARSHALL RICHARDS		14. MOTHER'S MAIDEN NAME MATTIE WILLIAMS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Victor Vincent Cosentino		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>174X I</b> CAUSE OF DEATH <b>Indurative Ca of Breast</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>170X II</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0 1963</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca of breast</b>	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5/7 19 68</b> to <b>5/7 19 68</b> , that (I) (we) last saw the deceased alive on <b>5/7 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Denis H. Tyra</b>		23B. DATE SIGNED <b>5/7/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Denis H. Tyra</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Bruzdinski Funeral Home</b>		ADDRESS <b>1407 Eastern Ave.</b>	

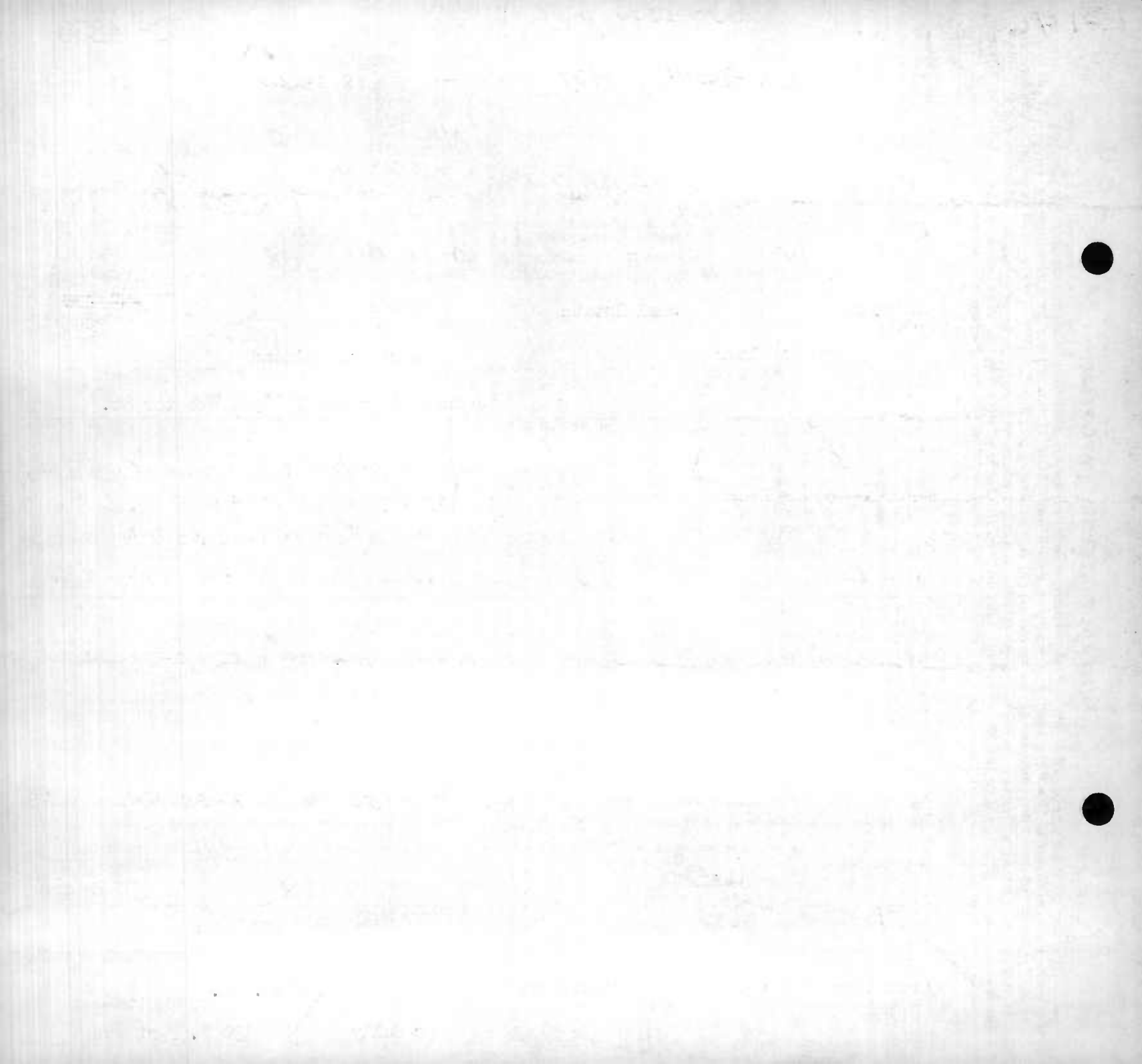
2-9-1972 - Letter from Victor Cosentino, Informant

HRS

55

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-4850</u>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>LAFLEUR, ADJUTOR L.</u>		2. DATE AND HOUR OF DEATH <u>8-35 PM on 5-3-68</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Washington D.C.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u>		C. CITY OR TOWN <u>Washington</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland</u>		E. STREET AND NUMBER <u>1536, 16th NORTH WEST-STREET</u>		
5. SEX <u>M.</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-1900</u>	9. AGE (In years lost birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>
12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>		13. FATHER'S NAME <u>Omer La Fleur</u>		
14. MOTHER'S MAIDEN NAME <u>Henrietta Guimond</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jeanne Biggerstaff</u>		
18. ADDRESS <u>1327 Webster St.</u>		19. CAUSE OF DEATH		
1B. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE <u>Acute posterior myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: <u>complicated E.A. dissociation.</u> (B) <u>Allogenic Shock secondary to</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Haematuria of 10 days duration</u>		
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>5-30 PM on 5-3-1968</u> to <u>8-35 PM</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-3-68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>5-3-68</u>		23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>
23D. ADDRESS <u>[Signature]</u>		23E. ADDRESS <u>[Signature]</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>5 8 68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u>
24D. LOCATION (City, town, or county) <u>Balto. Md.</u>		24E. LOCATION (State) <u>Balto. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR <u>Mc Gully</u>
25D. ADDRESS <u>130 E. Fort Ave</u>		25E. ADDRESS <u>130 E. Fort Ave</u>		



# FUNERAL DIRECTOR: IMPORTANT

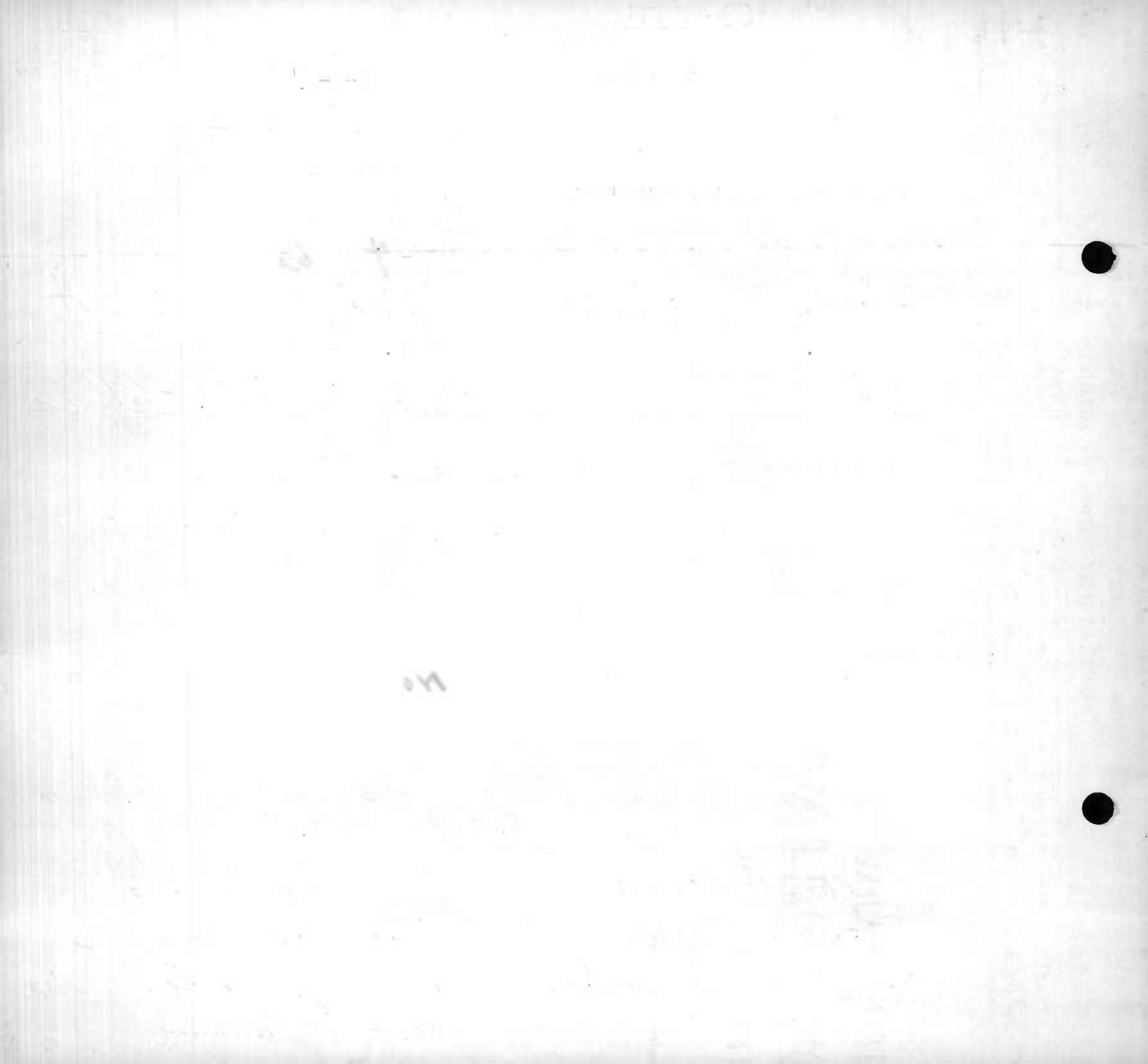
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4851

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-4851

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ADA E. BIGLER</b>		2. DATE AND HOUR OF DEATH <b>5-6-68</b> <b>4:00 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3 THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>A-A</b> C. CITY OR TOWN <b>SEVERNA PARK</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>R # 1 Box 445</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-04</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>@ home</b>		11. BIRTHPLACE (State or foreign country) <b>Ind</b>	
13. FATHER'S NAME <b>ROGER C. BAKER</b>			14. MOTHER'S MAIDEN NAME <b>ADA E. BROWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Stanley C. Bigler-Phone</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Congestive heart failure</b> (B) <b>Metastatic Ca of breast 4 yrs.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0 1963</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA of breast</b>		20A. AUTOPSY? (Yes or No) <b>NO.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>5/6 1968</b> to <b>5/6 1968</b> that (1) (we) last saw the deceased alive on <b>5/6 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dennis H. Tyras</b>				23B. DATE SIGNED <b>5/6/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dennis H. Tyras</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/9/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cem.</b>	
24D. LOCATION <b>Beth Co.</b>		24E. STATE <b>Ind</b>		24F. CITY, TOWN, or county	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Robert S. Bonamant</b>	
25D. ADDRESS <b>Severna Park, Md</b>					





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 4852

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>AMY FORD KREH</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>May 7, 1968 2:00 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 7, 1968 2:00 P.M.</b>	
6. SEX <b>female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>18 Nov 1899</b>		10. AGE (In years lost birthday) <b>68</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Practical Nurse</b>	
15. MOTHER'S MAIDEN NAME <b>Cora Whipp</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>212-24-5622</b>		18. INFORMANT <b>Wm. T. Kreh, Jr., Frederick, Md. 21701</b>	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (C) DUE TO, OR AS A CONSEQUENCE OF:		

20A. DATE OF OPERATION <b>4/22/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>5/7/68</b>
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount Olivet Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick, Md. 21701</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Frank R. Smith, Jr.</b> <b>M. R. Etchison &amp; Son, Frederick, Md. 21701</b>			

1930

XX

White

18 Nov 1909

John H. Ford

U. S.

Maryland

John H. Ford

Practical Nurse

Noted

700 Maxwell Ave.,

Wm. T. Kneib, Jr., Frederick, Md. 21701

no

Frederick, Md. 21701

Frederick, Md. 21701

Mount Oliver Cemetery

2/10/08

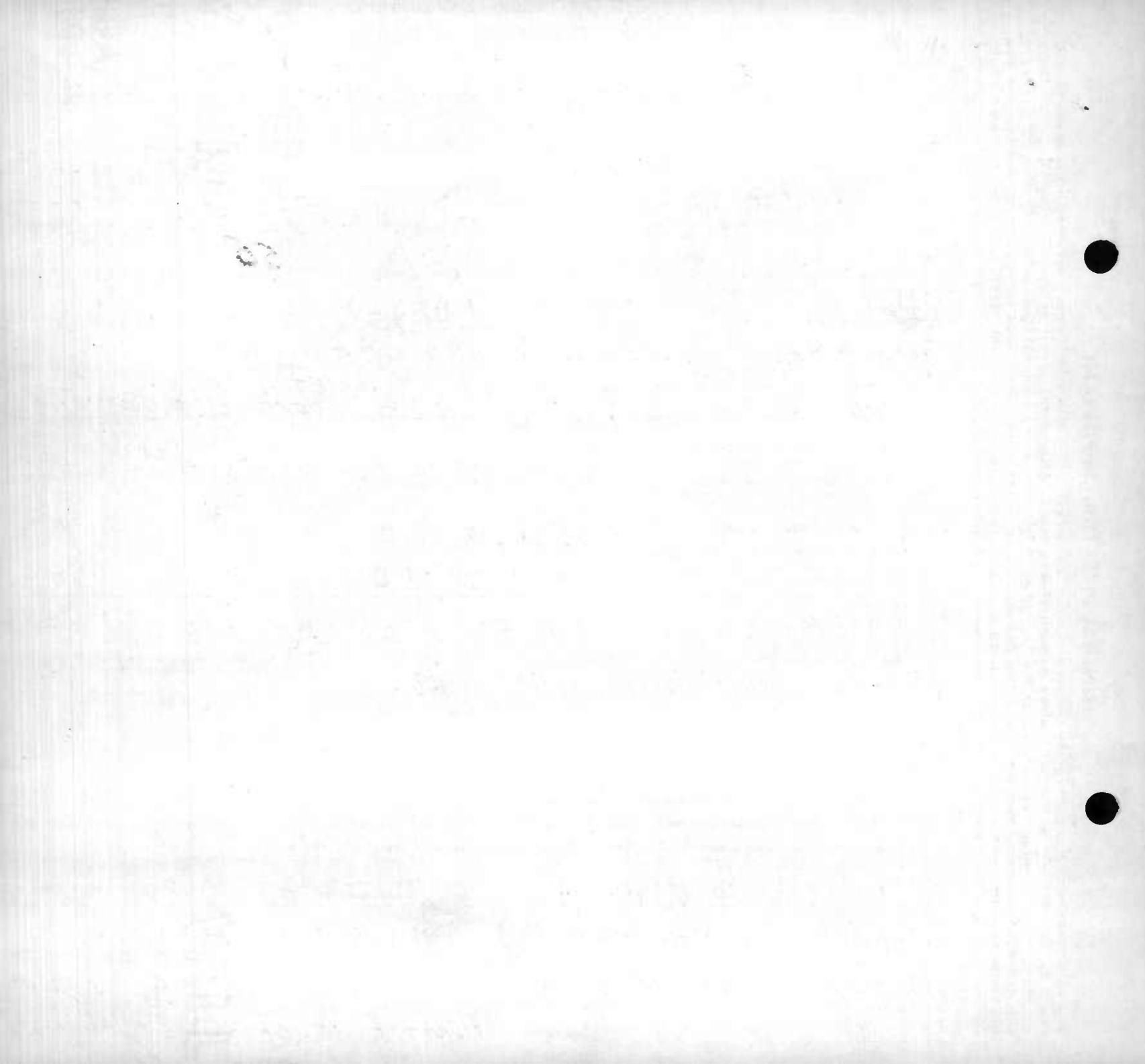
Burial

W. A. Robinson & Son, Frederick, Md. 21701

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

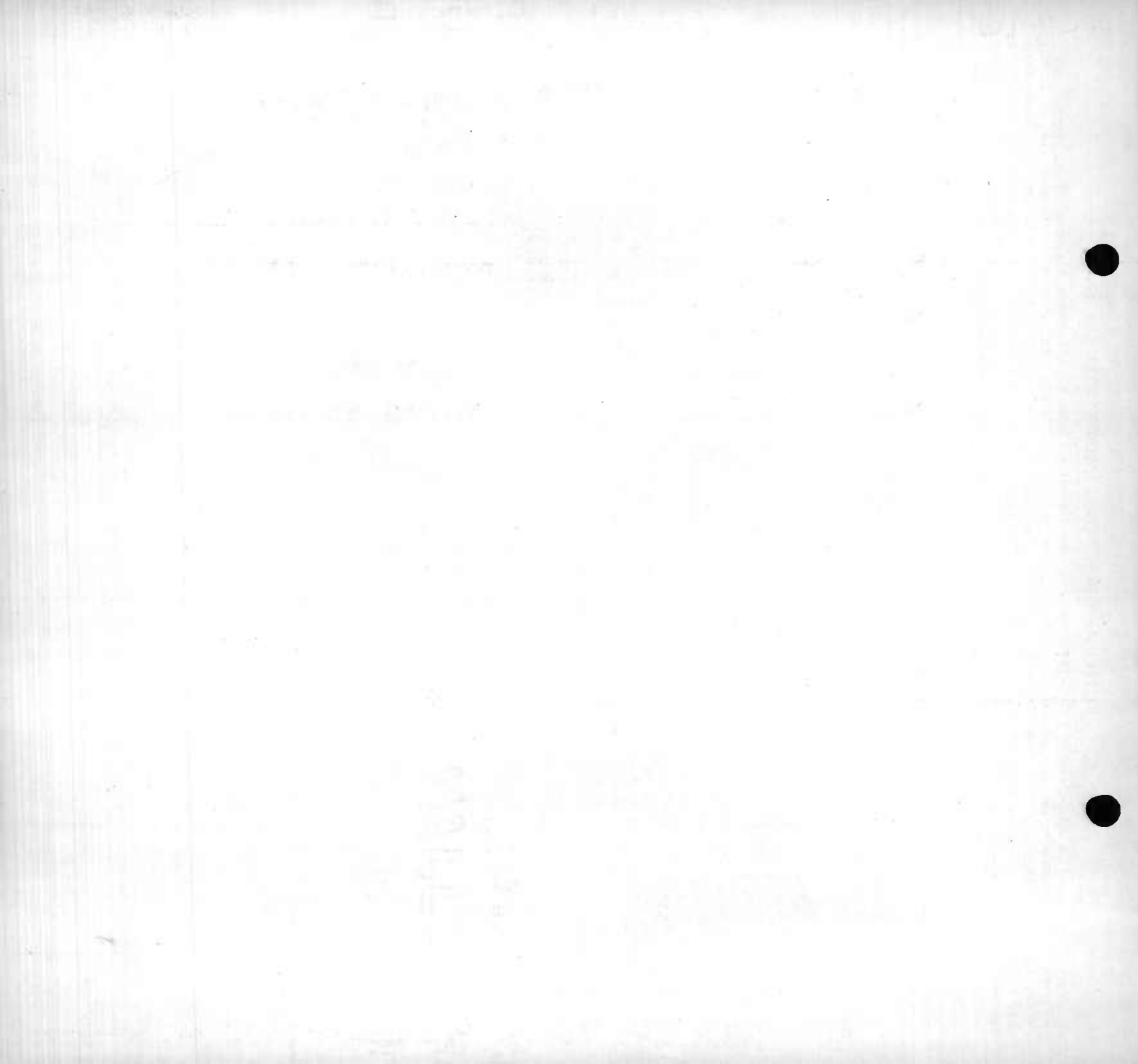
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4853
BIRTH NO.		68-4853		
1. NAME OF DECEASED (Type or Print) JANE E. LITTLEFIELD		2. DATE AND HOUR OF DEATH MAY 4, 1968 11:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND 38 HOSPITAL		E. STREET AND NUMBER SPRINGFIELD STATE HOSP.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/13/11	9. AGE (In years lost birthday) 56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATE HOSP.		10B. KIND OF BUSINESS OR INDUSTRY - GOV	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN GRANT JAMESON		14. MOTHER'S MAIDEN NAME MARTHA ELIZABETH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 7 -	17. INFORMANT MRS. MARGARET HOLLAND 9300 RIVERSIDE DR. FORT FOOT, MD	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE CEREBRAL HYPOXIA DUE TO, OR AS A CONSEQUENCE OF: (B) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (C) ATROPHIC PERFORATED GASTRIC ULCER		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS DAYS DAYS DAYS
MEDICAL CERTIFICATION				
19A. DATE OF OPERATION 5/2/68				
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED ULCER				
20A. AUTOPSY? (Yes or No) NO				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from MAY 1 1968 to MAY 5, 1968, that (I) (we) last saw the deceased alive on MAY 4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Charles M. Harrison MD		23B. DATE SIGNED 5/4/68		23C. PHYSICIAN'S NAME (Type) CHARLES M. HARRISON MD
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-7-68		24C. NAME OF CEMETERY or CREMATORY ST. MARYS
24D. LOCATION BAYTOWN MD.		24E. (City, town, or county) (State) CHARLES		
25A. DATE REC'D BY HEALTH DEPT. MAY 9 1968		25B. NAME OF REGISTRAR Ruth E. Johnson		25C. FUNERAL DIRECTOR HUNT FUNERAL HOME WILMINGTON, MD



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 4854		REG. NO.	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>GERTRUDE WEINBLATT</b>		2. DATE AND HOUR OF DEATH <b>May 7, 1968 10P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>03408 AVONDALE AVE</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>		C. CITY OR TOWN <b>BALTO</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>3408 AVONDALE RD</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 15, 1892</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACOB</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HYMAN WEINBLATT</b>		ADDRESS <b>SAME</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>3957 01X 174X</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Sclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>50 yrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the underlying condition last. <b>411X II</b>				(B) <b>Phenolic CVD</b> DUE TO, OR AS A CONSEQUENCE OF: <b>50 yr</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Ca 9 Breast, Ductal</b>				(C) <b>Ca 9 Breast, Ductal</b>		<b>12 yr</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1946</b> to <b>May 7, 1968</b> , and that (I) (we) last saw the deceased alive on <b>May 7, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Joseph B Gross</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Joseph B Gross</b>				23D. ADDRESS <b>6901 Parkview Rd</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/8/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Kresseth Memorial Park Wdwn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son, Inc</b>		ADDRESS <b>4610 Reisterstown Rd</b>	

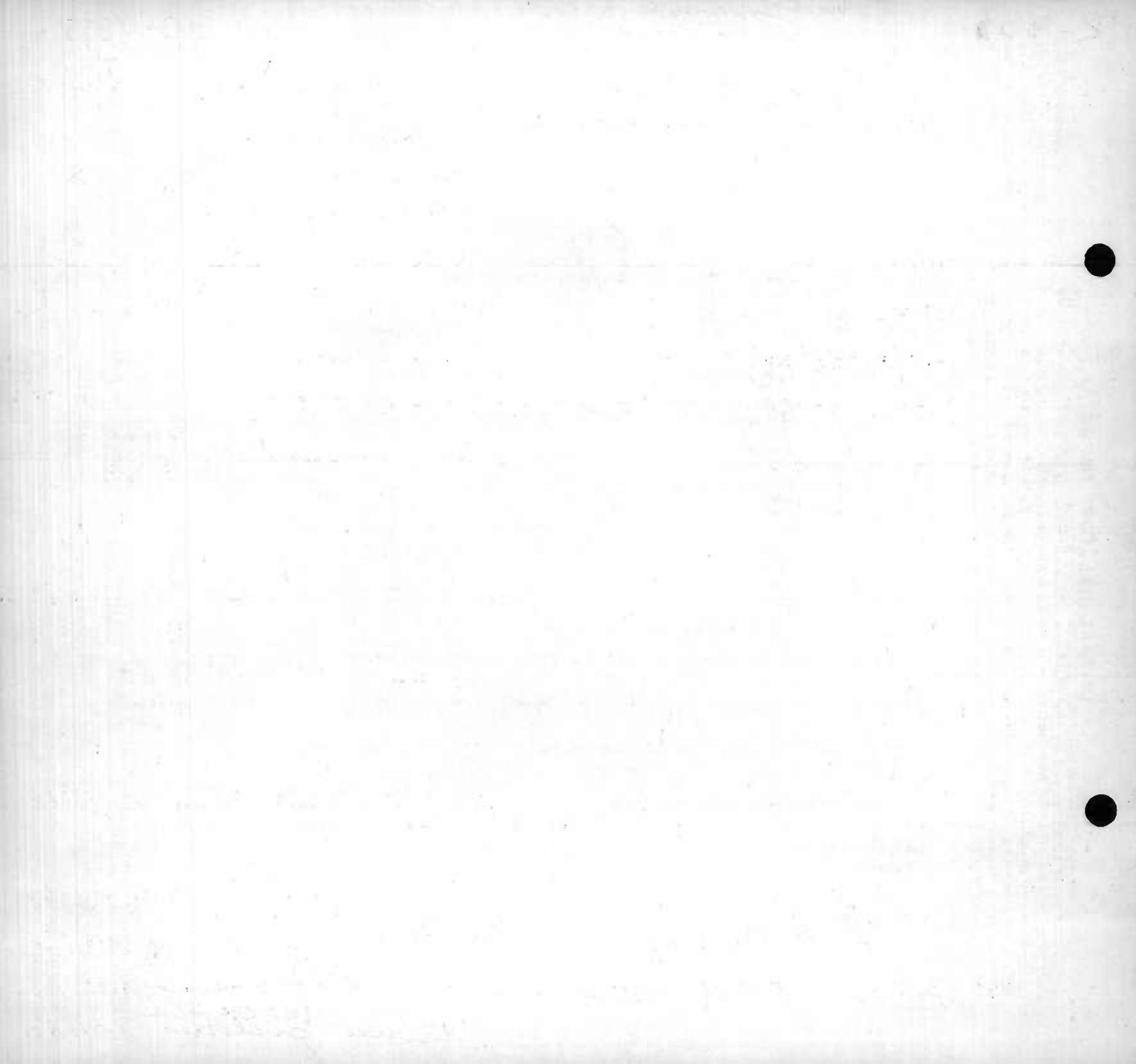


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4855</b>
68-4855				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>James B. Kyte</b>		
2. DATE AND HOUR OF DEATH <b>May 6, 1968</b>		7:45 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>NORTH CHARLES GEN. HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>49</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <b>MALE</b> 6. RACE <b>W</b>		E. STREET AND NUMBER <b>1826 Kingship Road</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-30-07</b> 9. AGE (In years last birthday) <b>60 yrs</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEEL INSPECTOR</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JAMES FRANK KYTE</b>		14. MOTHER'S MAIDEN NAME <b>Edna L Hammer</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War II</b>		16. SOCIAL SECURITY NO. <b>213074747</b>		17. INFORMANT <b>Lois C. Kyte</b>
18. <b>1631 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslerhenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of right lung with metastasis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
<b>163X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>May 5, 1968</b> to <b>May 6, 1968</b> , that (I) (we) last saw the deceased alive on <b>May 6, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>A. B. Paulino</b>		23B. DATE SIGNED <b>May 6, 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>H. B. Paulino</b>
23D. ADDRESS <b>North Charles General Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		
24B. DATE <b>5/9/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>MEADOW RIDGE</b>		24D. LOCATION (City, town, or county) (State) <b>2724 N. Charles, Balt. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR HOME ADDRESS <b>Funeral Home Address 4210 Ullrich Rd Bel Air Rd</b>

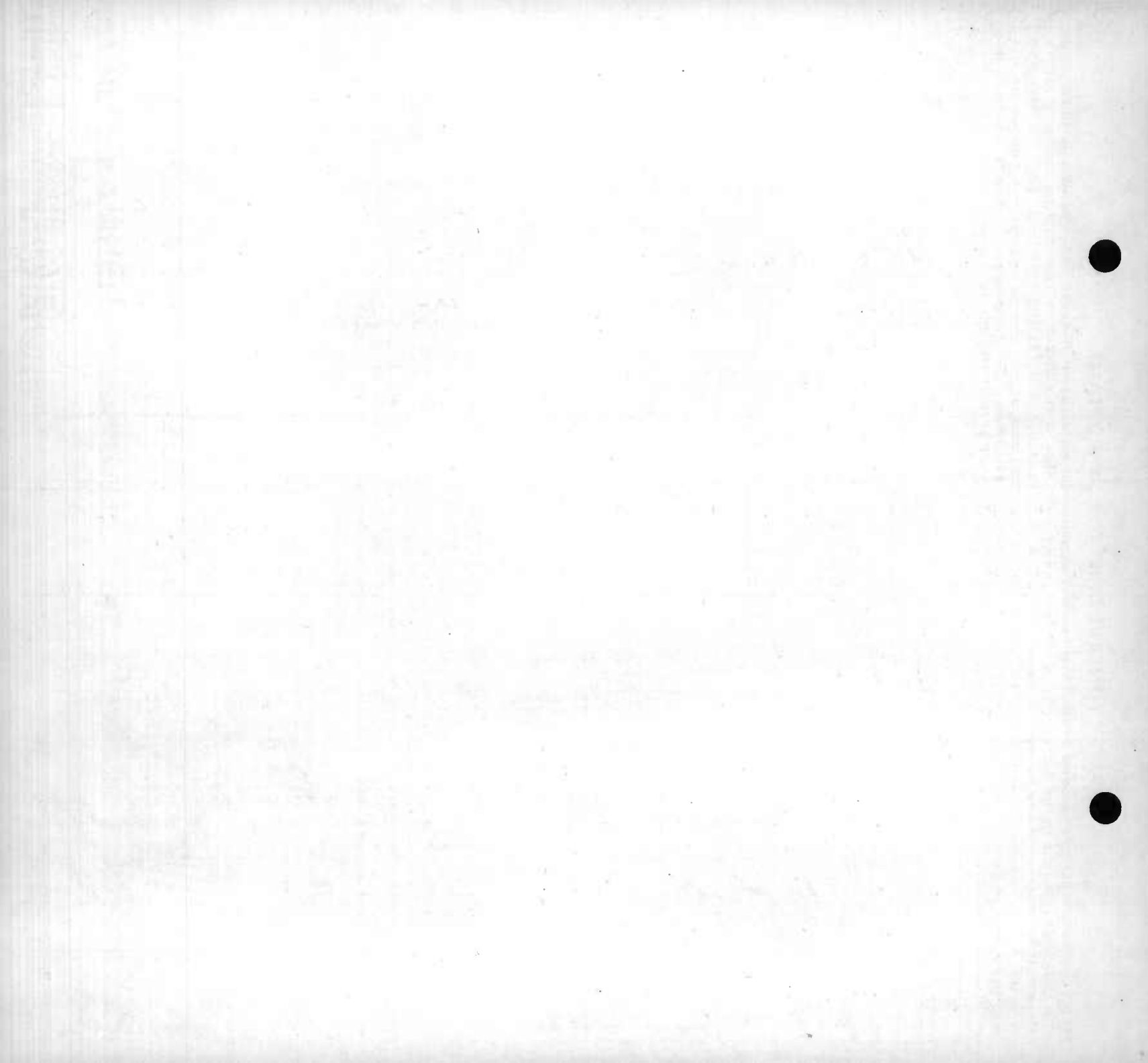




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4856	
1. NAME OF DECEASED (Type or Print) <b>PACUNAS, CHARLES V</b>		2. DATE AND HOUR OF DEATH <b>5/4/68 7:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>BALTO.</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>		C. CITY OR TOWN		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2410 PELHAM AVE</b>					
5. SEX <b>MALE</b>	6. RACE <b>CAUC.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/18</b>	9. AGE (In years last birthday) <b>89</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-03-3293</b>		17. INFORMANT <b>BERNARD PACUNAS-2410 PELHAM AV</b>	
18. <b>410.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Pulmonary edema</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ASCVD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30'</b> <b>24' years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>		<b>Fall &amp; injury to L, L3 out</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4 PM 5/3/68</b> to <b>7 AM 5/4/68</b> , that (I) (we) last saw the deceased alive on <b>5/3/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mr. Susan Bollinger M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/4/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ms. SUSAN BOLLINGER</b>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/7/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>CATHEDRAL CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Ulrich Funeral Home 11210 Belair</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-- 4857

# CERTIFICATE OF DEATH

REG. NO.

68-- 4857

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES GEGNER</b>		2. DATE AND HOUR OF DEATH <b>5-7-68</b> <b>9:40 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>35 ELMER HOME AND HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 ELMER HOME AND HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-24-88</b>	9. AGE (In years last birthday) <b>79</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEEL WORKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BETH. STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN GEGNER</b>		14. MOTHER'S MAIDEN NAME <b>MARY LOCKMAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>FRED L. MULLER NEPHEW</b> ADDRESS <b>430 S. HIGHLAND AVE.</b>	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PNEUMO - HYDROTHORAX</b> <b>PNEUMONIA</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <b>493X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 2</b> 19 <b>68</b> to <b>May 7</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>May 7</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Claverius J. Generation</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>May 7, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>GENERATION</b>		23D. ADDRESS <b>ELMER HOME &amp; HOSPITAL</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>LORRAINE MAUSOLEUM</b>	
24D. LOCATION <b>WOOD LAWN MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>ELMER FUNERAL HOME 4210 BELTIR</b>			

ENGLISH HOME AND HOSPITAL  
Baltimore  
430 S. HIGHLAND AVE  
BALTIMORE

NAME WHITE  
4-24-28

JOHN CORNEL  
STEEL WORKER BIRTH DATE  
HIGHLAND

4-24-28

LOCKMAN  
430 S. HIGHLAND AVE  
BALTIMORE

RESPIRATORY FAILURE

HYDRO THORAX

PNEUMONIA

May 1 1928  
May 2 1928  
May 3 1928

Johnson  
Baltimore

Cause same as above

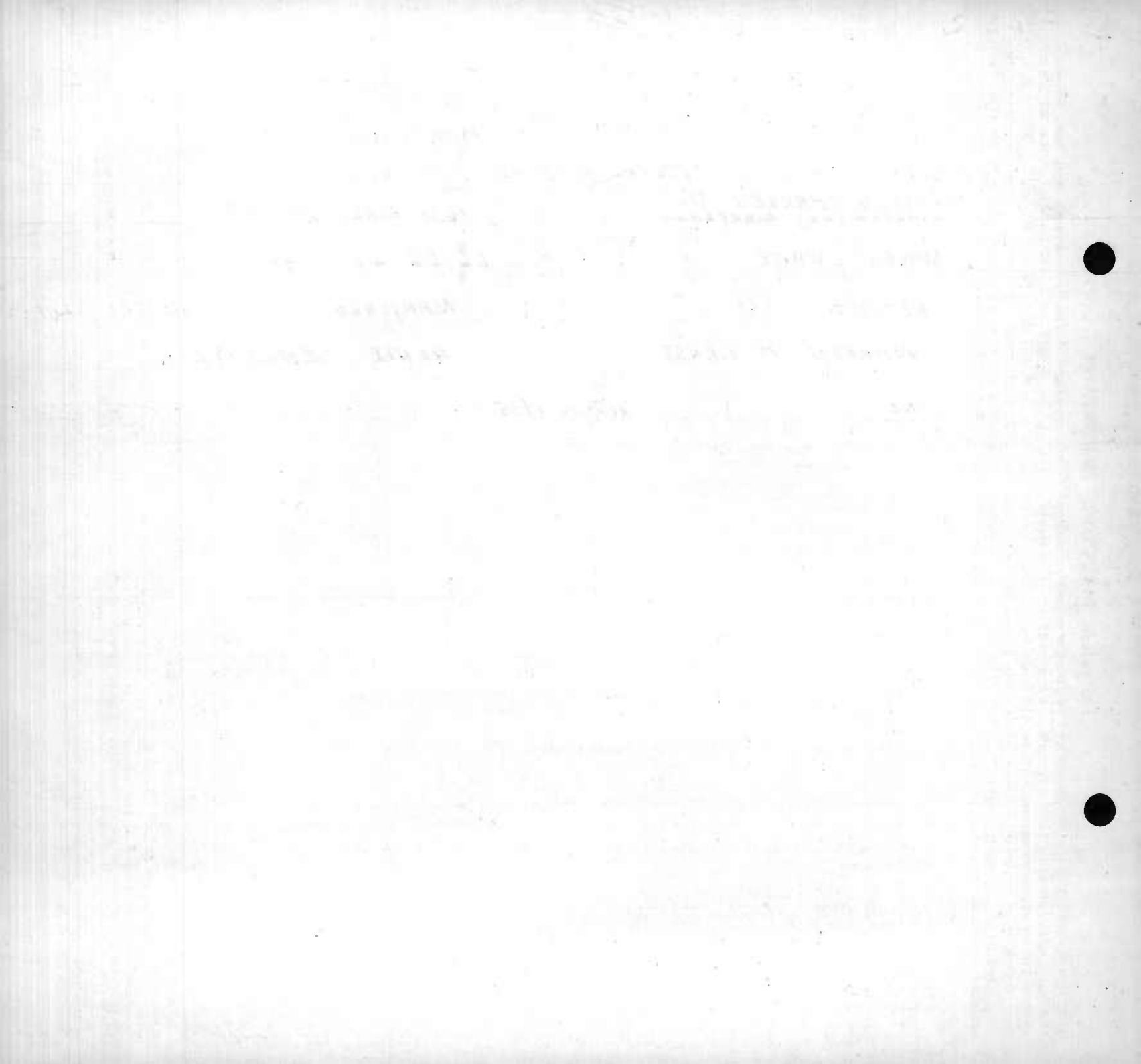
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 4858 CERTIFICATE OF DEATH

REG. NO. 68- 4858

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ERNST HARRY</b>		2. DATE AND HOUR OF DEATH <b>MAY 6, 1968</b>   <b>5:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>NORTH CHARLES GENERAL HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>NORTH CHARLES GENERAL HOSPITAL</b> <b>2700 N. CHARLES ST.</b> <b>BALTIMORE, MARYLAND</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1631 MALVERN ST.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>06 08 87</b>	9. AGE (In years last birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED GROCER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		13. FATHER'S NAME <b>WARREN H. ERNST</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE SCHWEITZER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-26-5435</b>		17. INFORMANT ADDRESS <b>MRS GERTRUDE ERNST 1631 MALVERN ST.</b>	
18. <b>440.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Heart arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Heart failure. Arteriosclerosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>433.0 II</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>4-28 1968</b> to <b>5-6-1968</b> , that (I) (we) last saw the deceased alive on <b>5-5 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Fernando de la Torre MD</b>				23B. DATE SIGNED <b>5-6-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>G. de la Torre MD</b>				23D. ADDRESS <b>North Charles General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/8/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>			
25B. NAME OF REGISTRAR <b>R. B. E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>ULLRICH FUNERAL HOME - DUNDALK MD</b>			

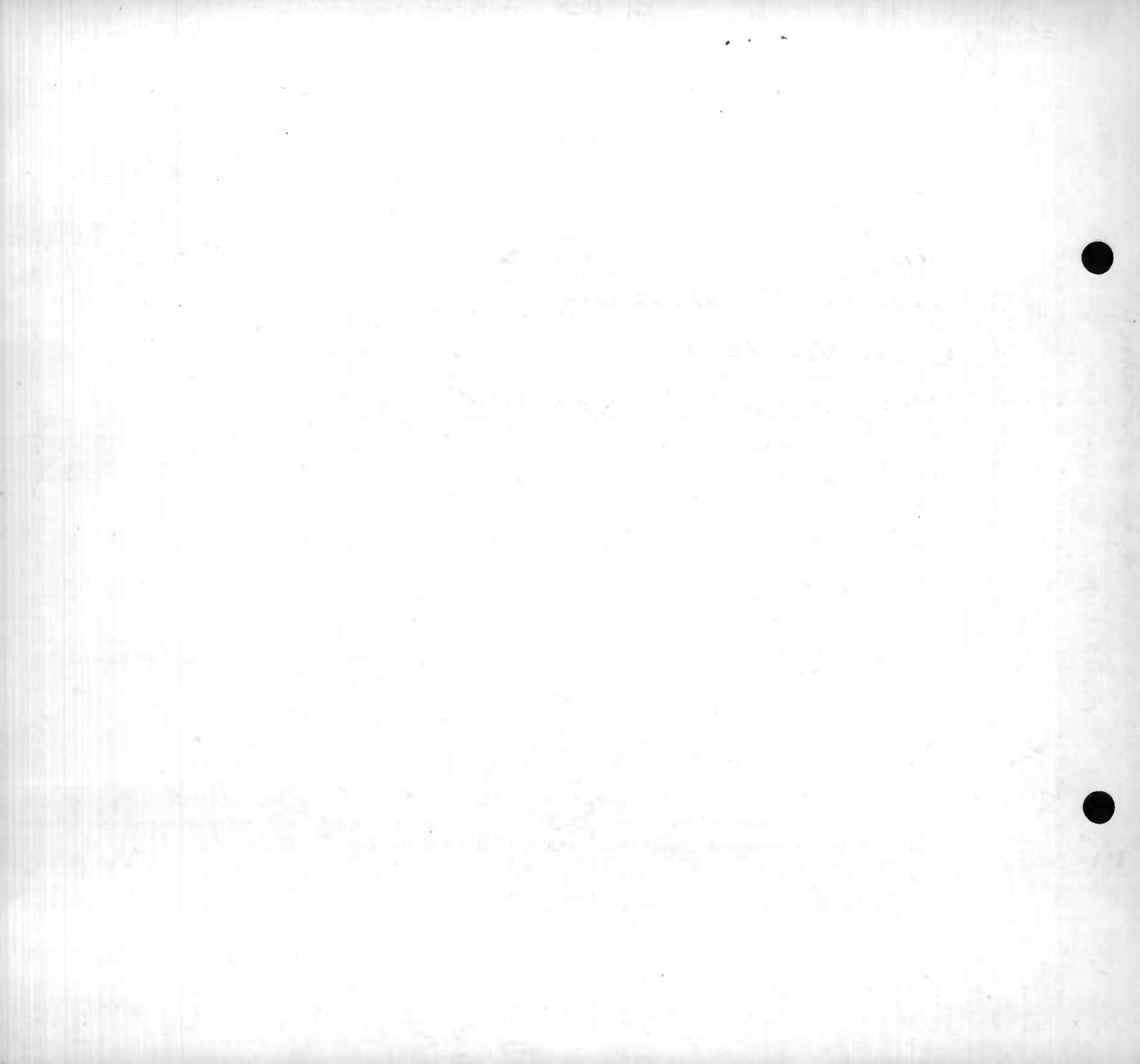




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4859	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>NATHANIAL MONTEGUE</i>		2. DATE AND HOUR OF DEATH <i>5/8/68</i> <i>12:50 A</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>38 UNIVERSITY</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 UNIVERSITY</i>			C. CITY OR TOWN <i>BALTO</i> D. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>		
			E. STREET AND NUMBER <i>909 N. FULTON AVE.</i>		
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>2/20/13</i>	9. AGE (In years last birthday) <i>55</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Rug Factory</i>		11. BIRTHPLACE (State or foreign country) <i>King William Co. VA</i>	
13. FATHER'S NAME <i>Johns Montague</i>			14. MOTHER'S MAIDEN NAME <i>Sarah Carter</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWII</i>		16. SOCIAL SECURITY NO. <i>218-10-4335</i>		17. INFORMANT <i>BERTIE MONTAGUE</i> ADDRESS <i>922 N FULTON AVE</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>4339 IT 303.2</i> (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <i>② MIDDLE CEREBRAL ARTERY THROMBOSIS</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASVD</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>332X II</i>			CHRONIC ALCOHOLISM		
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>APRIL 6</i> 19 <i>68</i> to <i>APRIL 8</i> 19 <i>68</i> , that (1) (we) last saw the deceased alive on <i>APRIL 7</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Frederick H. Senger</i>				23B. DATE SIGNED <i>5/8/68</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>5/10/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>BALTON NATIONAL</i>	
				24D. LOCATION (City, town, or county) (State) <i>BALTO MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 9 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Markham &amp; Hays</i> ADDRESS <i>387 Johns St</i>	



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68-4860 BALTIMORE CITY HEALTH DEPARTMENT

68-4860

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

INEZ

PATRICK

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

May

7,

1968

8:55 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00911 N. Fulton Avenue

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

May 7, 1968

8:55 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒NO ☐

6. SEX

female

7. RACE

negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

5-19-1934

10. AGE (In years  
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

911 N. Fulton Avenue

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

ERNEST MASON

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

LILLIE

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

LILLIE WHITE 945 WALTON C

19.

5-21-8

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Fatty Alteration of Liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

5-8-1-0

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Partial  
Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/7/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5/11/68

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

BALTO MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 9 1968

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

Marshall A. Hayes 638 N. Gilman St

ADDRESS

WALL & KIDDOCK

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1  
**3-525 68-4861** BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. **68-4861**

BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>EDGAR JOHNSON</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>5</b> <b>7</b> <b>68</b> <b>7:15 p.m.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2217 Etting St.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 7 1968 7:15 p.m.</b>				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>4-03</b>			
6. SEX <b>Male</b>		7. RACE <b>colored</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH <b>10-4-17</b>		10. AGE (In years last birthday) <b>50</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		E. STREET AND NUMBER <b>2217 Etting St.</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY				13. FATHER'S NAME <b>Edgar Johnson Sr.</b>			
15. MOTHER'S MAIDEN NAME <b>Hattie Stevenson</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Annie Yancy 525 Bloom St.</b>	
19. <b>412.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Cardiovascular Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. <b>422.1</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:											
21. <b>422.1</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>May 7 1968</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5/8/68</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>5-11-68</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>				24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>							
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>				25C. FUNERAL DIRECTOR ADDRESS <b>Kelson F. H. 1348 Calhoun Street</b>			

Robert M. White

BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO.			REG. NO. 68-4862
1. NAME OF DECEASED (Type or Print) RUBIN W. SANDERS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 4, 1968 Hour 9:50 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2340 Callow Avenue		3. DATE PRONOUNCED DEAD Month Day Year May 4, 1968 Hour 9:50 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11-12-39		10. AGE (In years lost birthday) 28	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Selida Sanders		ADDRESS 2430 Callow Avenue	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 282.5 + 3037 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E 2, 9, 2, 6 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Acute ethylism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5-5-68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-9-68	
24C. NAME OF CEMETERY or CREMATORY Sharon Cemetery		24D. LOCATION (City, town, or county) (State) Northumberland Co., Va.	
25A. DATE REC'D BY HEALTH DEPT. MAY 9 1968		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR		ADDRESS Kelson. F. H. 1348 N. Calhoun Street	



WALLLEY GEORGE

ALBANY, N.Y.

1871

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W-350

68- 4863 BALTIMORE CITY HEALTH DEPARTMENT

68- 4863

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CAVIN WHITEN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>5</b> Day <b>7</b> Year <b>68</b> Hour <b>8:05</b> p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Ma ryland Genera l Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>May</b> Day <b>7</b> Year <b>1968</b> Hour <b>8:05</b> p. M.	
6. SEX <b>Male</b> 7. RACE <b>Colored</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b>	
9. DATE OF BIRTH <b>5/22/00</b> 10. AGE (In years, lost birthday) <b>66</b> 11. BIRTHPLACE (State or foreign country) <b>Hagerstown Maryland</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF <b>U S A</b> 13. FATHER'S NAME <b>Harley Whiten</b>		E. STREET AND NUMBER <b>910 Stoddard Ct.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gaurd</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
15. MOTHER'S MAIDEN NAME <b>Maude Lyles</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>yes</b> <b>W W. I</b>	
17. SOCIAL SECURITY NO. <b>216-05-4454</b>		18. INFORMANT <b>Mrs Roseella Whiten</b> ADDRESS <b>910 Stoddard Court</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>4/12/21</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> = Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/13/68</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		25D. ADDRESS <b>1206 W North Ave</b>	

1911

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4864

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 4864

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary C. O'Neill

2. DATE AND HOUR OF DEATH

May 6, 1968 1140 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

203 S. Clinton St

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTYMD  
C. CITY OR TOWN D. INSIDE CITY LIMITS?  
Baltimore YES NOE. STREET AND NUMBER  
203 S. Clinton St

5. SEX

K

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

JUNE 30, 1892

9. AGE (In years  
last birthday)

75

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Rudolph Hamilton

14. MOTHER'S MAIDEN NAME

UNK

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

213-05-3341

17. INFORMANT

Mrs Ramsey

ADDRESS

3124 Foster

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Primary Carcinoma of

Stomach

(B) Secondary Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF:

Metastases to liver and left lung

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1965

57468

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

July '67

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

Ca. of stomach

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Nat White ☐

Work At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 66 19 66 to May 6 19 68

that (I) (we) last saw the deceased alive on May 6 19 68 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

George D. Lippy

DEGREE

Attending ☒ Phys.Med. ☐ DirectorStaff ☐ Phys.

23B. DATE SIGNED

578168

23C. PHYSICIAN'S  
NAME (Type)

George J. Lippy

DEGREE

23D. ADDRESS

426 S. Patterson Park Ave  
Baltimore Md 2123124A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

May 9, 1968

24C. NAME of CEMETERY or CREMATORY

New Cathedral

24D. LOCATION

Baltimore

(City, town, or county)

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

MAY 9 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Joseph M. Zeman

ADDRESS

263 CONKLING ST



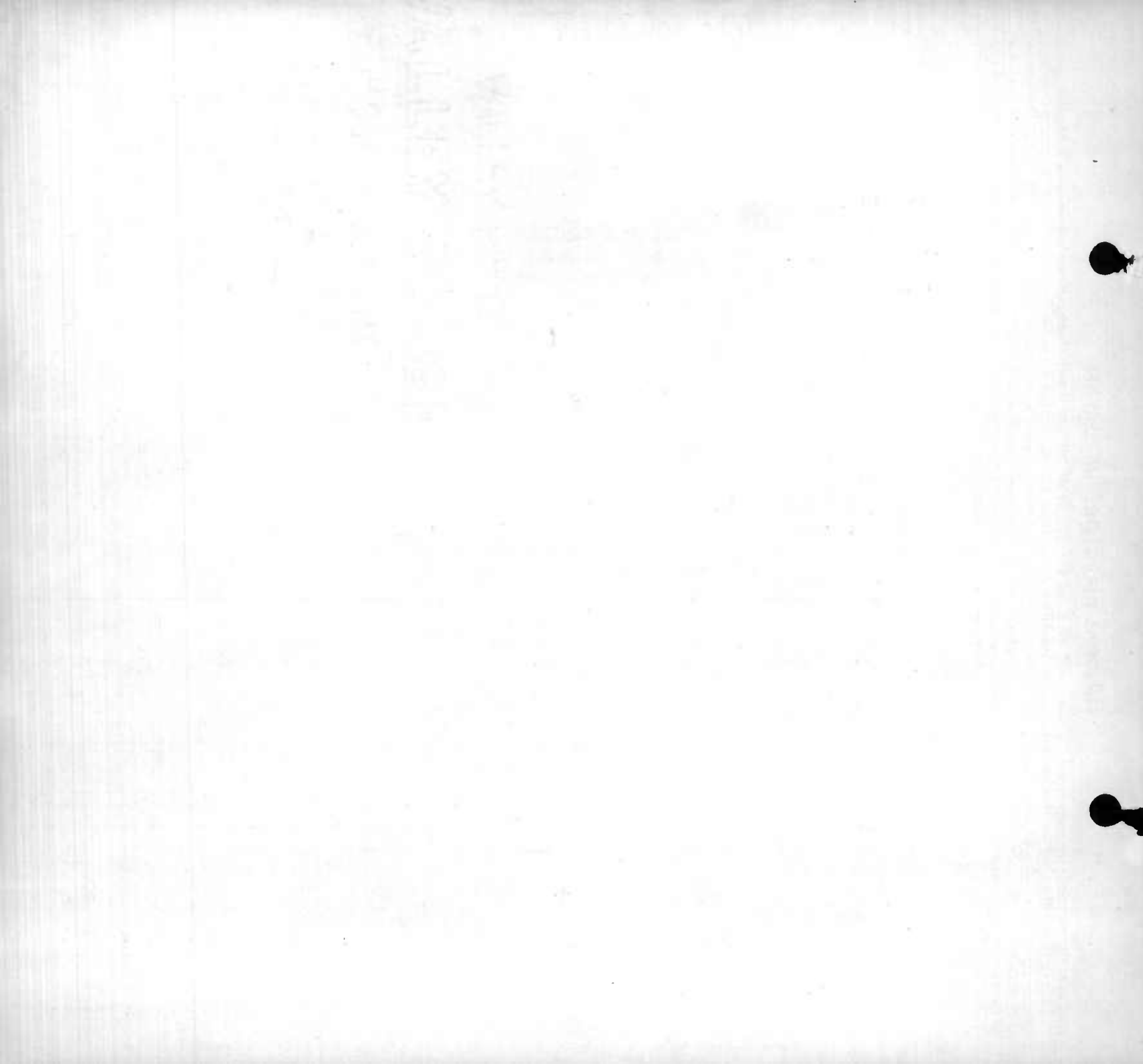
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4865 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 4865

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>POLLIE ANN POWELL</b>		2. DATE AND HOUR OF DEATH <b>5-7-1968</b> 12:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> 2007 Homewood Avenue Baltimore, Maryland 21218				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>2007 Homewood Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-25-1916</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>House of Welch</b>		11. BIRTHPLACE (State or foreign country) <b>Charlotte Court House, Virginia</b>			
13. FATHER'S NAME <b>Henry Lee</b>			14. MOTHER'S MAIDEN NAME <b>Estelle Ganes</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-18-7549</b>		17. INFORMANT <b>Mrs. Ruth Carey 2007 Homewood Ave. 21218</b>			
ADDRESS							
18. CAUSE OF DEATH							
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <b>I</b>  <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>            (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>            DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.         </td> <td style="width: 50%; vertical-align: top;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>             (A) IMMEDIATE CAUSE <i>Congestive Heart Failure</i>            DUE TO, OR AS A CONSEQUENCE OF:             (B) <i>hepatitis</i>            DUE TO, OR AS A CONSEQUENCE OF:             (C)         </td> </tr> </table>						<b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  (A) IMMEDIATE CAUSE <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF:  (B) <i>hepatitis</i> DUE TO, OR AS A CONSEQUENCE OF:  (C)
<b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  (A) IMMEDIATE CAUSE <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF:  (B) <i>hepatitis</i> DUE TO, OR AS A CONSEQUENCE OF:  (C)						
<b>593X II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <i>Anemia</i>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>November 28 1967</i> to <i>May 7 1968</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>May 3 1968</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <i>Jesse T. Holmes MD</i> DEGREE				23B. DATE SIGNED <b>5/8/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>Jesse T. Holmes MD</b> DEGREE				23D. ADDRESS <b>508 PENNELL AVE. Balt. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		24B. DATE <b>5-12-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Union Cemetery</b>			
24D. LOCATION (City, town, or county) (State) <b>Charlotte Court House, Va.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>					
25B. NAME OF REGISTRAR <i>Robert E. Fisk</i>		25C. FUNERAL DIRECTOR <b>1735 Harford Avenue ADDRESS Marshall W. Jones, Jr.</b>					





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

OTIS

WATKINS

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

May

7,

1968

1:50 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

001718 Brentwood Avenue

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

May 7, 1968

1:50 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

1-31-40

10. AGE (In years  
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1718 Brentwood Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Otis White

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

R.T. Bauer Co.

15. MOTHER'S MAIDEN NAME

Mildred Watkins

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

217-38-3524

18. INFORMANT

ADDRESS

Mrs. Rosetta Robinson 314 E. 28th St. 21218

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Fatty Alteration of The Liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

5-81.0 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/7/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5-11-68

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

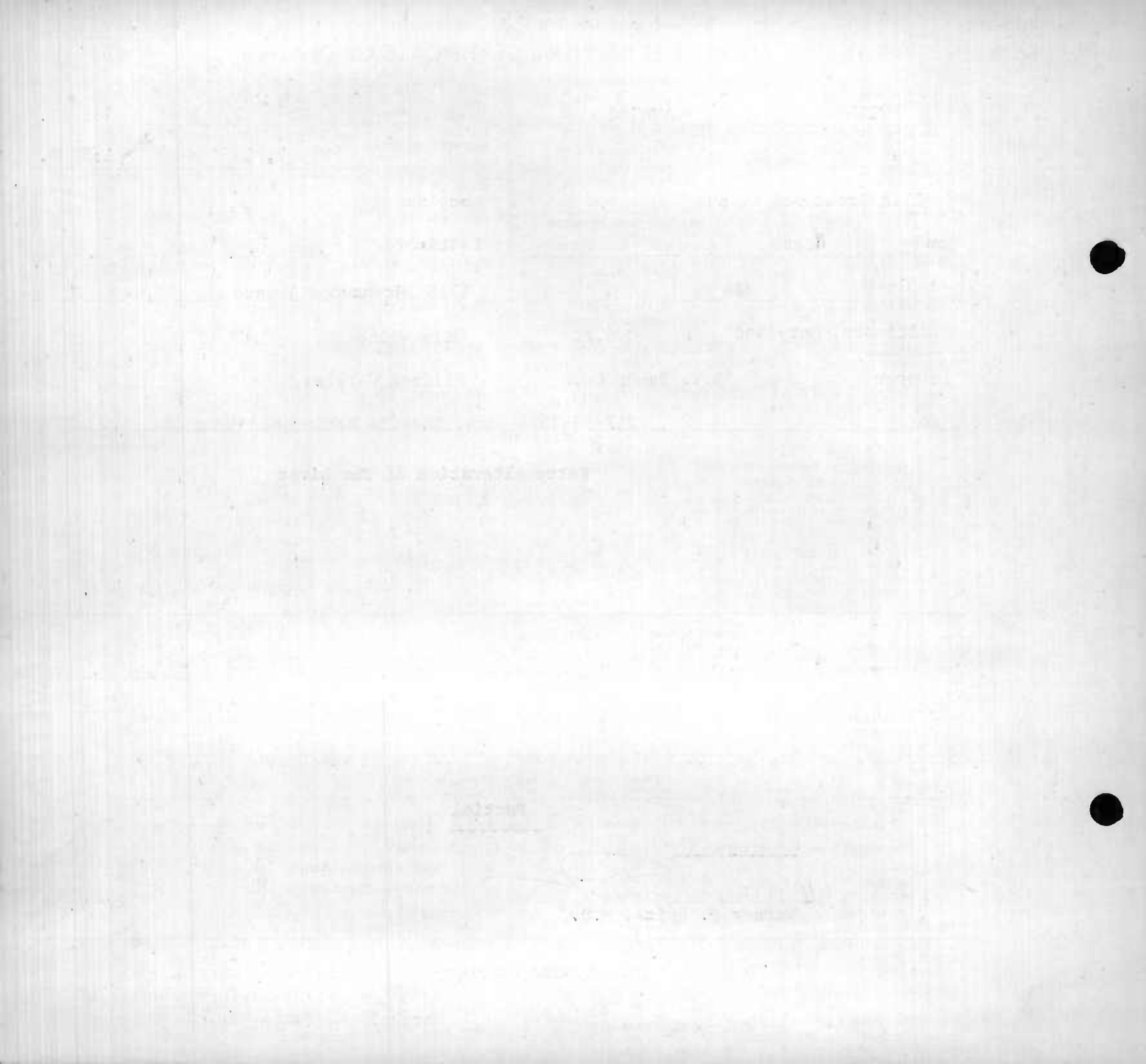
MAY 9 1968

25B. NAME OF REGISTRAR

Robert E. Farkas

25C. FUNERAL DIRECTOR 1735 Harford Avenue 21213

Marshall W. Jones, Jr.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4867

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 4867

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GARRETT, WELLINGTON</b>		2. DATE AND HOUR OF DEATH <b>5-5-68</b> <b>4:35</b> <b>P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>B OLTON HILL NURSING CENTER</b> <b>90</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> <b>20-10-1</b> <input type="checkbox"/> INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER <b>1820 W. LEXINGTON ST.</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-1885</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unk</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA (Alexandria)</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Jackson Garrett</b>		
14. MOTHER'S MAIDEN NAME <b>Barbara Trice</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>214 56 6791</b>			17. INFORMANT ADDRESS <b>ADMISSION RECORD - Bolton Nursing Home</b>		
18. <b>437.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebro Vasc. Accident</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Cerebro Vascular arteriosclerosis</b> <b>(C) ...</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>several yrs</b>			
19. <b>331X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>wasted left leg due to old polio several years</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 28</b> 19 <b>66</b> to <b>May 5</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>May 1</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (die not) view the body after death.					
23A. SIGNATURE <b>E. Ellsworth Gok</b> DEGREE				23B. DATE SIGNED <b>5-5-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. Ellsworth Gok</b> DEGREE				23D. ADDRESS <b>2431 Maryland Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/8/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus Balto Co. Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Hubert C. Mather 3035 W. North Ave</b>	

Continued from last page

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no

Continued from last page

Continued from last page

C-571L

68- 4868 BALTIMORE CITY HEALTH DEPARTMENT

68- 4868

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LAURA E CHAMBERS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>5 5 68 5:05 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 5 1968 5:05 p.m.</b>	
6. SEX <b>Female</b>		7. RACE <b>Colored</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15</b>	
9. DATE OF BIRTH <b>April 12, 1908</b>		10. AGE (In years last birthday) <b>60</b>	
11. BIRTHPLACE (State or foreign country) <b>Brandywine, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>G. Service Inc</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>577-22-0020</b>	
18. INFORMANT <b>Mr. Richard Chambers</b>		ADDRESS <b>2700 Elsinore Ave</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>443X</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>disease</b>	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>443X</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?</b>	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>No</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/8/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>	
25C. FUNERAL DIRECTOR <b>Herbert E. Nutter</b>		ADDRESS <b>3035 W. North Ave</b>	

RECEIVED

MAIL

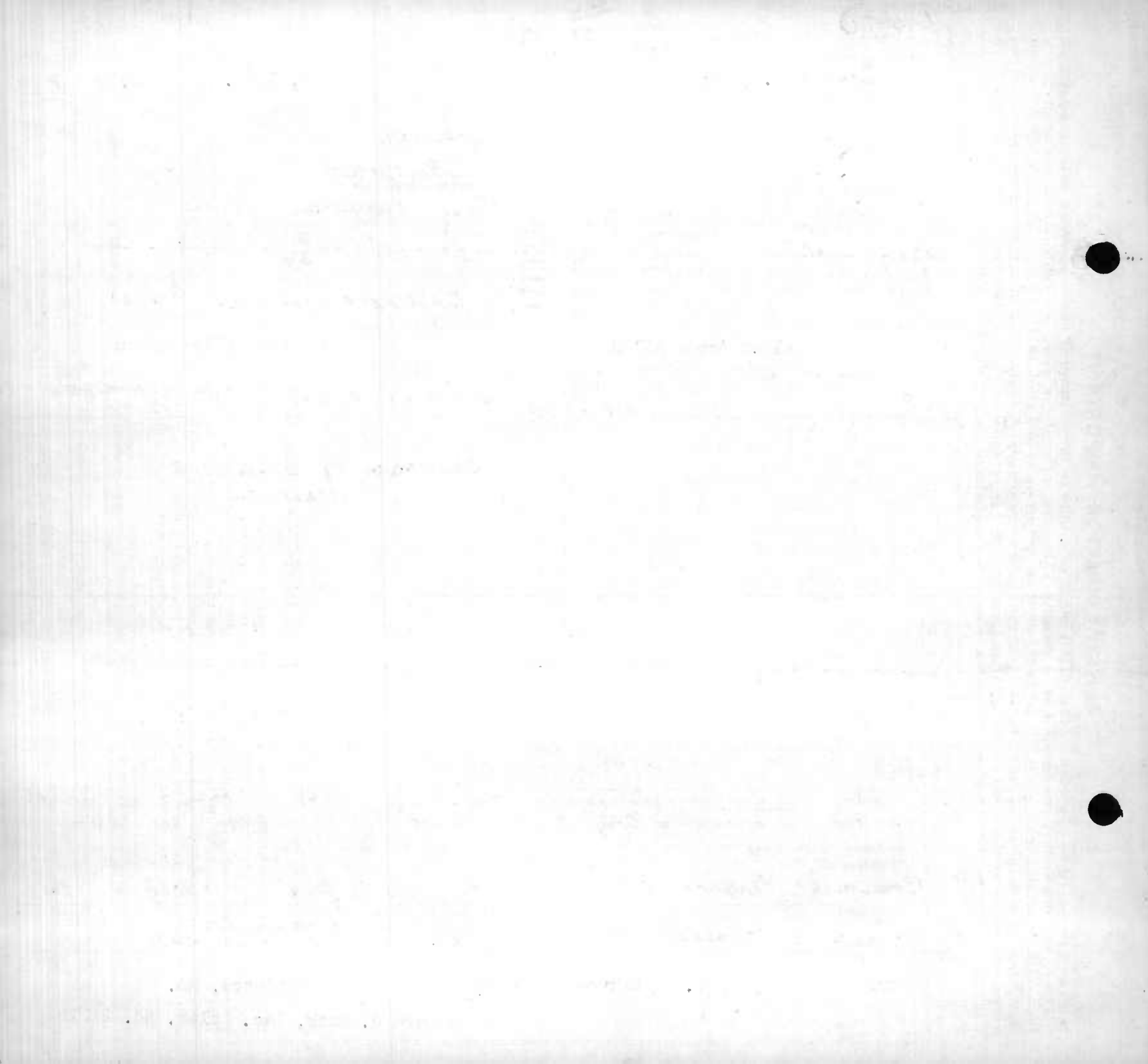
10/17/1918

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="font-size: 2em; font-weight: bold;">A-450</div> <div style="font-size: 1.5em; font-weight: bold;">68- 4869</div>		<div style="font-size: 1.2em; font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div>		<div style="font-size: 1.2em; font-weight: bold;">REG. NO. 68- 4869</div>	
<div style="font-size: 0.8em; font-weight: bold;">BIRTH NO.</div>		<div style="font-size: 0.8em; font-weight: bold;">1. NAME OF DECEASED</div> <div style="font-size: 0.8em;">(Type or Print) <b>DONALD A. ALLEN</b></div>		<div style="font-size: 0.8em; font-weight: bold;">2. DATE AND HOUR OF DEATH</div> <div style="font-size: 0.8em;"> <b>May 8, 1968.</b>     <b>1:10 P. M.</b> </div>	
<div style="font-size: 0.8em; font-weight: bold;">3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</div> <div style="font-size: 0.8em;">           FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>35 Church Home &amp; Hospital</b> </div>		<div style="font-size: 0.8em; font-weight: bold;">4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div style="font-size: 0.8em;">           A. STATE <b>MARYLAND</b>            B. COUNTY <b>BALTIMORE</b>            C. CITY OR TOWN <b>BALTIMORE</b>            D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            E. STREET AND NUMBER <b>3114 E. NORTHERN PKWY.</b> </div>			
<div style="font-size: 0.8em; font-weight: bold;">5. SEX</div> <div style="font-size: 0.8em;"><b>Male</b></div>	<div style="font-size: 0.8em; font-weight: bold;">6. RACE</div> <div style="font-size: 0.8em;"><b>White</b></div>	<div style="font-size: 0.8em; font-weight: bold;">7. MARRIED</div> <div style="font-size: 0.8em;"> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>            WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> </div>	<div style="font-size: 0.8em; font-weight: bold;">8. DATE OF BIRTH</div> <div style="font-size: 0.8em;"><b>5-14-08</b></div>	<div style="font-size: 0.8em; font-weight: bold;">9. AGE (In years last birthday)</div> <div style="font-size: 0.8em;"><b>59</b></div>	<div style="font-size: 0.8em; font-weight: bold;">If Under 1 Yr. Months: Days: Hours: Min.</div>
<div style="font-size: 0.8em; font-weight: bold;">10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div>		<div style="font-size: 0.8em; font-weight: bold;">10B. KIND OF BUSINESS OR INDUSTRY</div>		<div style="font-size: 0.8em; font-weight: bold;">11. BIRTHPLACE (State or foreign country)</div> <div style="font-size: 0.8em;"><b>BALTIMORE, MARYLAND</b></div>	
<div style="font-size: 0.8em; font-weight: bold;">12. CITIZEN OF WHAT COUNTRY?</div> <div style="font-size: 0.8em;"><b>USA</b></div>		<div style="font-size: 0.8em; font-weight: bold;">13. FATHER'S NAME</div> <div style="font-size: 0.8em;"><b>Walter Scott Allen</b></div>			
<div style="font-size: 0.8em; font-weight: bold;">14. MOTHER'S MAIDEN NAME</div> <div style="font-size: 0.8em;"><b>Mary Dallam Allen</b></div>		<div style="font-size: 0.8em; font-weight: bold;">15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div style="font-size: 0.8em;"><b>No</b></div>			
<div style="font-size: 0.8em; font-weight: bold;">16. SOCIAL SECURITY NO.</div> <div style="font-size: 0.8em;"><b>218 128348</b></div>		<div style="font-size: 0.8em; font-weight: bold;">17. INFORMANT ADDRESS</div> <div style="font-size: 0.8em;"> <b>DOROTHY ALLEN</b>     <b>3114 E. NORTHERN PKWY.</b> </div>			
<div style="font-size: 0.8em; font-weight: bold;">18. CAUSE OF DEATH</div> <div style="font-size: 0.8em;">           DISEASE OR CONDITION DIRECTLY LEADING TO DEATH            (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)            ANTECEDENT CAUSES            DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.         </div>					
<div style="font-size: 0.8em; font-weight: bold;">19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</div> <div style="font-size: 0.8em;"> <b>ASCVD &amp; CONGESTIVE HEART FAILURE</b> </div>					
<div style="font-size: 0.8em; font-weight: bold;">19A. DATE OF OPERATION</div> <div style="font-size: 0.8em;"><b>1810</b></div>		<div style="font-size: 0.8em; font-weight: bold;">19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>		<div style="font-size: 0.8em; font-weight: bold;">20A. AUTOPSY? (Yes or No)</div> <div style="font-size: 0.8em;"><b>NO</b></div>	
<div style="font-size: 0.8em; font-weight: bold;">21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</div>		<div style="font-size: 0.8em; font-weight: bold;">21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div>		<div style="font-size: 0.8em; font-weight: bold;">21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div>	
<div style="font-size: 0.8em; font-weight: bold;">21D. TIME OF INJURY (APPROX.)</div>		<div style="font-size: 0.8em; font-weight: bold;">21E. INJURY OCCURRED</div> <div style="font-size: 0.8em;">           While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> </div>		<div style="font-size: 0.8em; font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>	
<div style="font-size: 0.8em; font-weight: bold;">22. I certify that (I) (this hospital) attended the deceased from <b>May 7, 1968</b> to <b>May 8, 1968</b>, that (I) (we) lost saw the deceased alive on <b>May 8, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>					
<div style="font-size: 0.8em; font-weight: bold;">23A. SIGNATURE</div> <div style="font-size: 0.8em;"><b>Corazon Z. Vergara, M.D.</b></div>				<div style="font-size: 0.8em; font-weight: bold;">23B. DATE SIGNED</div> <div style="font-size: 0.8em;"><b>May 8, 1968</b></div>	
<div style="font-size: 0.8em; font-weight: bold;">23C. PHYSICIAN'S NAME (Type)</div> <div style="font-size: 0.8em;"><b>CORAZON Z. VERGARA, M.D.</b></div>				<div style="font-size: 0.8em; font-weight: bold;">23D. ADDRESS</div> <div style="font-size: 0.8em;"><b>Church Home &amp; Hospital Baltimore, Maryland 21231</b></div>	
<div style="font-size: 0.8em; font-weight: bold;">24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div style="font-size: 0.8em;"><b>Burial</b></div>	<div style="font-size: 0.8em; font-weight: bold;">24B. DATE</div> <div style="font-size: 0.8em;"><b>5/11/68</b></div>	<div style="font-size: 0.8em; font-weight: bold;">24C. NAME OF CEMETERY OR CREMATORY</div> <div style="font-size: 0.8em;"><b>Parkwood Cemetery</b></div>		<div style="font-size: 0.8em; font-weight: bold;">24D. LOCATION (City, town, or county) (State)</div> <div style="font-size: 0.8em;"><b>Baltimore, Md.</b></div>	
<div style="font-size: 0.8em; font-weight: bold;">25A. DATE REC'D BY HEALTH DEPT.</div> <div style="font-size: 0.8em;"><b>MAY 9 1968</b></div>		<div style="font-size: 0.8em; font-weight: bold;">25B. NAME OF REGISTRAR</div> <div style="font-size: 0.8em;"><b>Robert E. Talley</b></div>		<div style="font-size: 0.8em; font-weight: bold;">25C. FUNERAL DIRECTOR ADDRESS</div> <div style="font-size: 0.8em;"><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b></div>	





J-525

68-4870

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-4870

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH JENKINS JR.

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour  
5 7 68 6:15 p M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3. DATE PRONOUNCED DEAD Month Day Year Hour  
May 7 1968 6:15 p M.5. USUAL RESIDENCE (Where deceased lived: If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX 1143 N. Carey St.

Male Colored

B. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

11/11/02

10. AGE (In years lost birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1143 N. Carey St.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Joseph Jenkins

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Hannah Moore

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go or unknown) (If yes, give war or dates of service)  
No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Alberta Coffria 1406 W. Franklin St.

19. 412.4 + 185X CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Cancer of the prostate

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/8/68

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5/10/68

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Pk.

24D. LOCATION

(City, town, or county)

Arbutus, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 9 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.

11/11/68

North Carolina

U.S.A.

Joseph Jenkins

Hannah Moore

Alberta College 1408 W. Frank

*David M. [unclear]*

Detail

5/10/68

Arborea Memorial Hk. Arborea, Maryland

Charles A. Rice 681 W. [unclear]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-620		68-4871		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4871	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) GROSS, BERTHA IRENE				2. DATE AND HOUR OF DEATH MAY 8, 1968 10:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21223 B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE, MARYLAND 21229				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2107 WILHELM STREET							
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-01	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM D. DORSEY				14. MOTHER'S MAIDEN NAME Denny Linstid			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-20-6124		17. INFORMANT ADDRESS 4 ST. AGNES HOSPITAL RECORDS			
18. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 15y	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/29 1968 to 5/8 1968, that (I) (we) last saw the deceased alive on 5/8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 1055							
23A. SIGNATURE Raymond Bahr MD				23B. DATE SIGNED 5/8/68		23C. PHYSICIAN'S NAME (Type) RAYMOND BAHR, MD.	
23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-11-68		24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE MEMORIAL		24D. LOCATION (City, town, or county) (State) Howard County, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 9 1968		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR GEO. L. SCHWAB Funeral Home Francis N. Miller 2101 Frederick Ave.			

1922

WATSON  
1000

1000

WATSON

1000

1000

1000

R-352

68- 4872 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 4872

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HELEN RIDINGER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>5 8 68 8:30p M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 2808 Fredrick Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 8 1968 8:30 pm.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>DEC 3, 1920</b>		10. AGE (In years last birthday) <b>47</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>		17. SOCIAL SECURITY NO. <b>220-22-9015</b>	
15. MOTHER'S MAIDEN NAME <b>Henrietta Wilkinson</b>		18. INFORMANT <b>OTTO RIDINGER</b>	
19. CAUSE OF DEATH <b>398X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Rheumatic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) _____ (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>716X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>None</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20-06</b>	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	
22D. TIME (Month) (Day) (Year) (Hour) <b>None</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>None</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>None</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5-9-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-11-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>First Christian Church</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jankowski</b>	
25C. FUNERAL DIRECTOR <b>Geo. L. Schwab Funeral Home</b>		25D. ADDRESS <b>Francis W. Miller 2101 Frederick Ave</b>	

1808

Dec 3, 1920

Mr Robert Abell, Jr

W. S. H.

Marjorie

Marjorie W. Kinsman

Dorothy

Marjorie

220-22-212 Otto Kinsman

W. S. H.

Robert Abell

8-11-22 Mr Christian Church

Book

See a photo of the book  
in the photo of the book



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RELEASED AS NOT A MEDICAL EXAMINER'S CASE BY DR. WILSON OF THE MEDICAL EXAMINER'S

BIRTH NO. <b>D-120</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68-4873</b>
1. NAME OF DECEASED (Type or Print) <b>CHARLES DAVIS</b>		2. DATE AND HOUR OF DEATH <b>600 5-5-68 6 PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>CITY OF BALTIMORE</b>		
5. SEX <b>M</b>		6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/14</b>
9. AGE (In years lost birthday) <b>54</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chaffuer</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>William H. Davis</b>		
14. MOTHER'S MAIDEN NAME <b>Emma Wilson</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Clara Small</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>4-31-91-5-21-0</b>		CAUSE OF DEATH <b>E. Coli meningitis &amp; septicemia</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Bacterial Hematoma</b>		
(B) <b>Bilat. Subdural Hematoma Evacuation</b>		(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>331X II</b>		<b>LAENKE'S CHIRROSIS</b>		
19A. DATE OF OPERATION <b>4-17-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SUBDURAL HEMATOMA</b>		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>4-11-68</b> 19 to <b>5-5</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5-5</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Dennis W. Schumeta MD</b>		23B. DATE SIGNED <b>5-5-68</b>		23C. PHYSICIAN'S NAME (Type) <b>DENNIS W. SCHUMETA</b>
23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>5-10-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Calvary Em</b>		24D. LOCATION (City, town, or county) (State) <b>D.C. W Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Rayner Sanders</b>
25D. ADDRESS <b>217 E. Preston St</b>				

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M-15068-4874

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-4874

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY MAYBIN

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

2:50 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Mercy Hospital DDA

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

2:50 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

B. COUNTY

Maryland

6. SEX

Female

7. RACE

colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

2-11-22

10. AGE (In years  
lost birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

921 McDonogh St.

11. BIRTHPLACE (State or foreign country)

Chester, S.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard Johnson

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

None

15. MOTHER'S MAIDEN NAME

Carrie Johnson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

John Maybin

ADDRESS

Same

19.

4122 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Hypertensive arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

443X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 7, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5-9-68

24C. NAME OF CEMETERY or CREMATORY

Cypress Hills Station Co.

24D. LOCATION

(City, town, or county)

(State)

Chester S. Caroline

25A. DATE REC'D BY HEALTH DEPT.

MAY 9 1968

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Edward F. Wilson

ADDRESS

WALTON POLICE

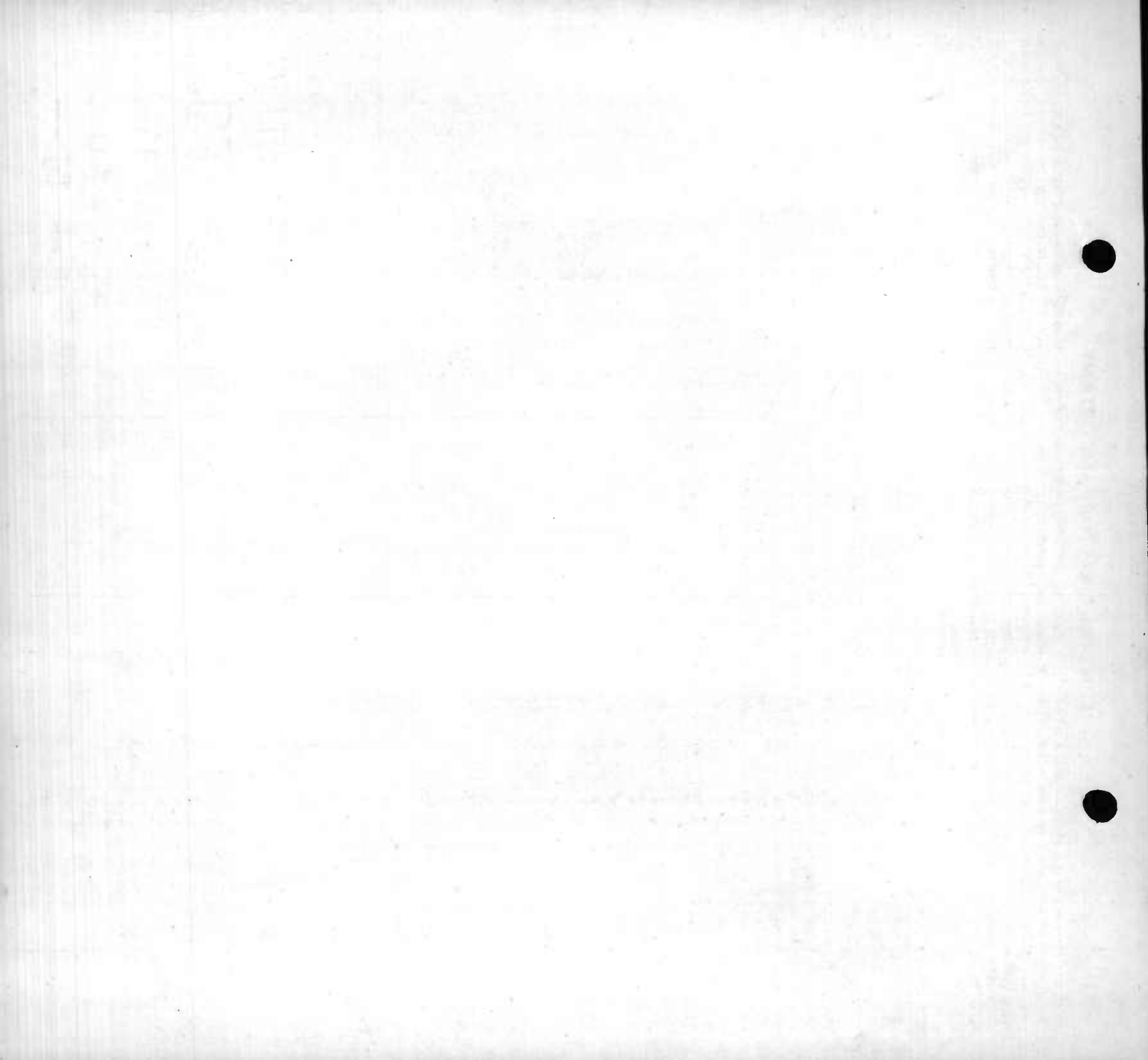
5-11-55

2-2-55  
2-2-55

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 4875	
68- 4875 CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EDWARD AUGUSTON</b>		2. DATE AND HOUR OF DEATH <b>5-4-68</b> <b>8:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>FRANKLIN Square Hospital 36</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1807 NORTH BRUCE ST.</b>		
5. SEX <b>Male</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-24-08</b>	9. AGE (In years lost birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>EDNA MOUSLEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>SEPTICEMIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>BRONCHOPNEUMONIA</b> <b>CONGESTIVE HEART FAILURE</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-24-68</b> 19 to <b>5-4-68</b> 19, that (I) (we) last saw the deceased alive on <b>5-4-68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Christina A. Feliciano M.D.</b> DEGREE				23B. DATE SIGNED <b>5-4-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHRISTINA A. FELICIANO M.D.</b> DEGREE				23D. ADDRESS <b>FRANKLIN SQ HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-8-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cmt</b>	
24D. LOCATION <b>G.A. Church Md.</b>		24E. CITY, town, or county <b>BALTIMORE</b>		24F. STATE <b>MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Ernest Wilson</b>	
25D. ADDRESS		25E. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4876	
BIRTH NO. 68- 4876		CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print) <b>BARNETT, THOMAS M.</b>		2. DATE AND HOUR OF DEATH <b>May 6, 1968</b>		11:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Prince Georges 66-00</b> C. CITY OR TOWN <b>Marlow Heights</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5930- 28th Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-28-02</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Military Service</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
13. FATHER'S NAME <b>Thomas Barnett</b>		14. MOTHER'S MAIDEN NAME <b>Jessie Forbes</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 2-15-28 to 5-1-50</b>		16. SOCIAL SECURITY NO. <b>252-82-6248</b>		17. INFORMANT <b>Records</b> ADDRESS <b>V.A. Hospital, Baltimore, Maryland 21218</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Paralytic ileus</b> DUE TO, OR AS A CONSEQUENCE OF: <b>3 days</b>			
(C) <b>Post-operative</b> DUE TO, OR AS A CONSEQUENCE OF: <b>5 days</b>					
19A. DATE OF OPERATION <b>5/1/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of rectum</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 17, 19 68</b> to <b>May 6, 19 68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 6, 19 68</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard F. Kieffer, Jr.</b>		23B. DATE SIGNED <b>5/8/68</b>		23C. ADDRESS <b>VAH, Baltimore, Maryland 21218</b>	
24A. BURIAL CREATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-10-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arlington Nat'l</b>	
24D. LOCATION (City, town, or county) <b>Saltzman, Va</b>		24E. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
24G. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		24H. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		24I. FUNERAL DIRECTOR <b>Robert E. Taylor, M.D.</b>	



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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-4877</u>
<b>BIRTH NO.</b> <u>L-550</u> <b>1. NAME OF DECEASED</b> (Type or Print) <u>Frederick, Mr.</u>		<b>CERTIFICATE OF DEATH</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		<b>2. DATE AND HOUR OF DEATH</b> <u>5-4-68</u> <u>12 15</u> A.M. <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>FREDERICK</u> <b>C. CITY OR TOWN</b> <u>FREDERICK</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>ROUTE 3 WILLIS LANE</u>		
<b>5. SEX</b> <u>MALE</u>	<b>6. RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7-3-67</u>	<b>9. AGE</b> (In years last birthday) <u>10</u> <u>1</u> <u>1</u> If Under 1 Yr. Months: Days: Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Frederick, Maryland</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>JAMES LEHMAN</u>		
<b>14. MOTHER'S MAIDEN NAME</b> <u>JANET SMITH</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mr. James L. Lehman</u> <b>ADDRESS</b> <u>Rt. # 3, Frederick, Md.</u>		
<b>18. CAUSE OF DEATH</b>				
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <u>Wongluin &amp; jejunal atresia</u>				
<b>19A. DATE OF OPERATION</b> <u>2-6-68</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>jejunal atresia</u>		<b>20A. AUTOPSY?</b> Yes or No <u>No</u>
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <u>No</u>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>21F. HOW DID INJURY OCCUR?</b>		<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>7-3-1967</u> <b>to</b> <u>5-4-1968</u> <b>that (I) (we) last saw the deceased alive on</b> <u>5-3-1968</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.</b>		
<b>23A. SIGNATURE</b> <u>W.C. McLean Jr. MD</u> <b>Attending</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>				<b>23B. DATE SIGNED</b> <u>5-4-68</u>
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>W.C. McLEAN</u>				<b>23D. ADDRESS</b> <u>THE JOHNS HOPKINS HOSPITAL</u>
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>5-6-1968</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Resthaven Memorial Gardens</u>
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Frederick County, Maryland</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>MAY 9 1968</u>		
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Dailey</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Robert E. Dailey &amp; Son</u>		
<b>ADDRESS</b> <u>Frederick, Md.</u>				

Mo

P-120

68- 4878

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 4878

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE PAPPAS

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month Day Year Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3. DATE  
PRONOUNCED DEAD

Month Day Year Hour

April 18, 1968

9:40 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years  
last birthday)  
78If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

10 E. Pratt Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

5/9/68

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

JOHNS HOPKINS MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAY 9 1968

Robert E. Farley, M.D.

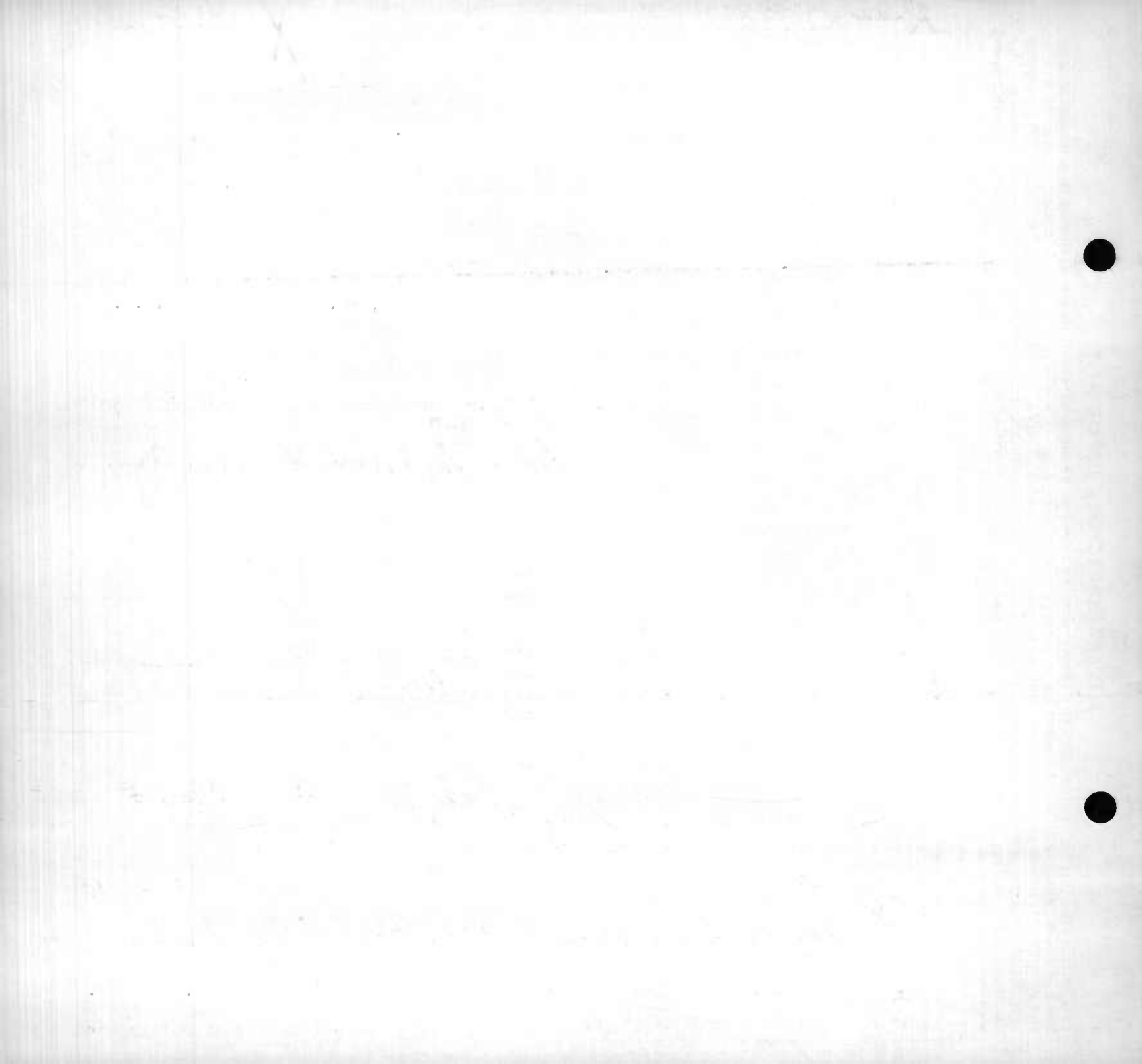
MORTUARY SERVICE - BCHO



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		Registered No. <b>68- 4879</b>	
BIRTH NO. <b>R-200</b> M.E. CASE NO. <b>68- 4879</b>		1. NAME OF DECEASED (Type or Print) <b>Wilhelmina Ross</b>	
2. DATE AND HOUR OF DEATH <b>5- 5- 1968</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Harford Gardens</b>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balt Co.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>7140 Golden Ring Road</b>		5. SEX <b>Female</b> 6. RACE <b>Cauc.</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>8- 21- 1879</b> 9. AGE (In years last birthday) <b>88</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Riemenschneider</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Pencil</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-48-4950JL</b>	
17. INFORMANT <b>Mr Conrad Ross</b>		ADDRESS <b>21237 8301 Philadelphia Road</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardio-Vascular Disease 2 years</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
19A. DATE OF OPERATION <b>422.1 II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (This hospital) attended the deceased from <b>Feb 14 19 68</b> to <b>May 5 19 68</b> , that (I) (we) last saw the deceased alive on <b>May 3 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Loy M. Zimmerman</b>		23B. DATE SIGNED <b>5/5/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Loy M. Zimmerman</b>		23D. ADDRESS <b>3202 Harford Rd, Baltimore, Md.</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-8-1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Zion Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Road</b>	





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4880	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>MASON</b> <b>HARRIET MAULSBY</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>5/8/68</b> <b>9:15 A.M.</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>44 Union Memorial Hosp</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> <b>1424 PARK AVE</b>			
<b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <b>44 Union Memorial Hosp</b>		<b>5. SEX</b> <b>F</b>		<b>6. RACE</b> <b>W</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>6/9/4 1904</b>		<b>9. AGE</b> (In years last birthday) <b>63</b>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>VIRGINIA - Middleburg</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>DANIEL K. SMITH</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>LUCY ADAMS</b>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>219-26-3949</b>	
<b>17. INFORMANT</b> <b>husband-</b> <b>David Lee Maulsby, 1424 Park Av., Balto.</b>		<b>ADDRESS</b> <b>21217</b>			
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Rupture of heart</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute myocardial infarction</b> <b>Arteriosclerotic coronary thrombosis</b>					
<b>19A. DATE OF OPERATION</b> <b>4/20/68</b>					
<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>II</b>					
<b>20A. AUTOPSY?</b> (Yes or No) <b>Yes</b>					
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>					
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (the hospital) attended the deceased from</b> <b>5/6</b> <b>19 68</b> <b>to</b> <b>5/8</b> <b>19 68</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>5/8</b> <b>19 68</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>W. H. Oehlert</b>				<b>23B. DATE SIGNED</b> <b>5/8/68</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Dr. William H. Oehlert</b>				<b>23D. ADDRESS</b> <b>The Union Memorial Hospital</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>May 11, 1968</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>St. Mary's,</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Emmorton, Harford Co., Md.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 10 1968</b>			
<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Fisher</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Stewart &amp; Mowen Co. 108 W. North Av. Cityl</b>			

Report of the  
Anti-Slavery  
Committee of the  
General Assembly

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68-- 4881 CERTIFICATE OF DEATH

REG. NO. 68-- 4881

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DILLINGER, HARRY MELVIN</b>		2. DATE AND HOUR OF DEATH <b>May 7 - 68 7:10 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>11 St - Timothy Lane 21228</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Md. Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>8 Rte. Md 21201</b>		C. CITY OR TOWN <b>DATONSVILLE</b>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>Bulls Co 53-00</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-13-04</b>	9. AGE (In years lost birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Military Lt. Master</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Md. State 5<sup>th</sup> Reg Army</b>		11. BIRTHPLACE (State or foreign country) <b>N.J.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN M. DILLINGER</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA FISHER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Chart</b>	
18. <b>396.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRO VASCULAR</b> <b>RHEUMATIC AORTIC MITRAL</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>CHRONIC HEART FAILURE</b> (C) ...		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>410X II</b>					
19A. DATE OF OPERATION <b>May 3-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Heart Valve Disease</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-21-68</b> 19 to <b>5-7-68</b> 19, that (I) (we) last saw the deceased alive on <b>5-7-68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. H. Gonzalez</b>		DEGREE		23B. DATE SIGNED <b>7 May 68</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. H. GONZALEZ</b>		DEGREE		23D. ADDRESS <b>University of Md. Hospital 8 Rte. Md. 21201</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5-9-68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>London Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	25C. FUNERAL DIRECTOR <b>Frederic Covarrubias</b>		ADDRESS <b>Datonville, Md.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4882	
<div style="display: flex; justify-content: space-between;"> <span>5-536</span> <span>68-4882</span> <span>CERTIFICATE OF DEATH</span> </div>					
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>  <b>1. NAME OF DECEASED</b>                      (Type or Print) <u>ROSE SCHNEIDER</u> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <u>5/6/68</u> <u>12<sup>25</sup></u> <u>pm</u> </div> </div>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <u>42 Sinai Hospital of Balto.</u> </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b>  </div> </div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b>  <u>MARYLAND</u> </div> <div> <b>B. COUNTY</b>  </div> </div>		
<b>5. SEX</b> <u>FEMALE</u>			<b>6. RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>AT HOME</u>		<b>8. DATE OF BIRTH</b> <u>87</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>AUSTRIA</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>SAMUEL FELZENBERG</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>NETTIE FELZENBERG</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>218-52-2438</u>		<b>17. INFORMANT</b> <u>MR. MARVIN WAGHELSTEIN, 920 HYDE ROAD</u> <u>SILVER SPRING, MARYLAND 20902</u>	
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div> <b>(A) IMMEDIATE CAUSE</b>  <u>CVA</u>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b> </div> <div> <b>(B)</b>  <u>ASCVD with acute and</u>  <u>chronic heart failure</u>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b> </div> <div> <b>(C)</b>  </div> </div>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 days</u>  <u>unknown</u>	
<b>422.1 II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> 		<b>20A. AUTOPSY? (Yes or No)</b> 	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>5/3</u> <u>1968</u> <b>to</b> <u>5/6</u> <u>1968</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>5/6/68</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Kenneth Wetcher MD</u>				<b>23B. DATE SIGNED</b> <u>5/6/68</u>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <u>KENNETH WETCHER MD</u>				<b>23D. ADDRESS</b> <u>Sinai Hospital, Balto, Md</u>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>24B. DATE</b> <u>5-7-68</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>ANSHE KEMUNAH (AITZ CHAIM)</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>MAY 10 1968</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Fisher</u>		<b>25C. FUNERAL DIRECTOR</b> <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			



# FUNERAL DIRECTOR: IMPORTANT

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G-615		68-4883		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4883	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Gorfine Yetta.</i>			
2. DATE AND HOUR OF DEATH <i>5-7-68 at 9.50 PM</i>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 Sinai Hospital of Baltimore</i>				C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>8009 Arrowhead Rd.</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-24-1877</i>	9. AGE (In years lost birthday) <i>90</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>RIGA, LITHUANIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <del>XXXXXXXXXX</del> <i>JACOB KAHN</i>				14. MOTHER'S MAIDEN NAME <i>HANNAH &amp; POSSELTINER</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>218-46-2392</i>		17. INFORMANT <del>XXXXXXXXXX</del> <i>MR. CHARLES GORFINE</i>		ADDRESS <i>22 LIGHT STREET #21202</i>	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>163X II</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac arrest</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Pleural effusion (Malignant?)</i> (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>163X II</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5-7-68</i> 19 to <i>5-7-68</i> 19, that (I) (we) last saw the deceased alive on <i>5-7-68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>5-7-68</i>			
23C. PHYSICIAN'S NAME (Type) <i>[Signature]</i>				23D. ADDRESS <i>SINAI HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5-9-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>CHIZUK AMUNO (ARLINGTON)</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1968</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS.</i>		ADDRESS <i>6010 REISTERSTOWN ROAD</i>	



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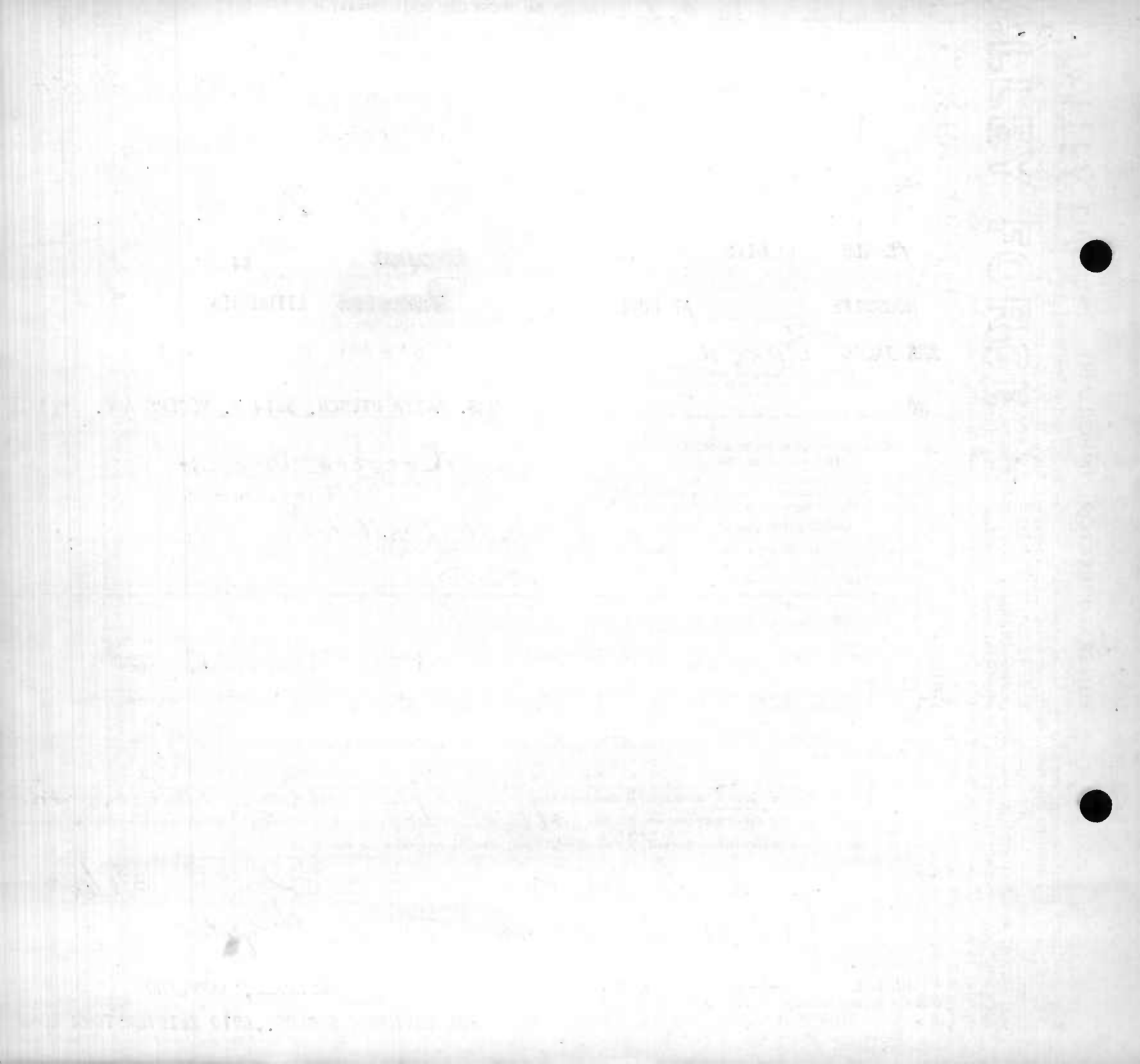
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-260		68-4884		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4884	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>ESTHER TUCKER</b>			
2. DATE AND HOUR OF DEATH <b>5/8/68 6:15 A.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <b>3814 W. ROGERS AVE</b>	
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>[REDACTED]</b>	
9. AGE (In years lost by) <b>84</b>		If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JACOB BAKER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. ANITA HIRSCH, 3814 W. ROGERS AVE. #21215</b>		18. CAUSE OF DEATH <b>CEREBRAL VASCULAR THROMBOSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Atrial fibrillation</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b>		(C)	
19. DATE OF OPERATION <b>4/33/1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>5/3</b> 19 <b>68</b> to <b>5/8</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5/7</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Joseph Gimber MD</b>	
23B. DATE SIGNED <b>5/8/68</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSEPH GIMBER MD</b>		23D. ADDRESS <b>Denair Hospital</b>		24. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
24B. DATE <b>5-9-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>KOVNA</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Friedman</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		25D. ADDRESS		25E. DATE	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-4885</u>
BIRTH NO. <u>68-4885</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>McParlan ROSE A WELLS</u>		2. DATE AND HOUR OF DEATH <u>5-7-68</u> <u>6:00 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>35 CHURCH HOME AND HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Sauk</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 CHURCH HOME AND HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-22-88</u> 9. AGE (In years last birthday) <u>79</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>England</u>
13. FATHER'S NAME <u>JAMES McParlan</u>		14. MOTHER'S MAIDEN NAME <u>MARY MURPHY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216/10/4761</u>		17. INFORMANT <u>JOHNA PRICE</u> ADDRESS <u>6206 Otis St., Hyattsville, Md. 20785</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>250.92 182.9</u> <u>CEREBRO VASCULAR ACCIDENT</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>DIABETES MELLITUS</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>260x II</u> <u>CANCER OF THE UTERUS</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION <u>3-20-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>II</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>3-20-68</u> to <u>5-7-68</u> , that (I) (we) last saw the deceased alive on <u>5-7-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Veneracion Jr.</u>		23B. DATE SIGNED <u>May 7, 1968</u>		23C. PHYSICIAN'S NAME (Type) <u>VENERACION Jr.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/10/1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sacred Heart of Jesus</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1968</u>		
25B. NAME OF REGISTRAR <u>Walter Brooks Bradley</u>		25C. ADDRESS <u>Walter Brooks Bradley, Inc., Dundalk</u>		

(NAME OF THE CLIENT)

DIRECTOR GENERAL

GENERAL SECRETARY

JOHN SEVER

UNION

UNKNOWN

REMARKS

FORM WHITE

CHURCH HOME AND HOSPITAL

1941 DUNDAS AVE

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RECEIVED

11-22-38

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-- 4886 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68-- 4886

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Louis J. Whipp</b>		2. DATE AND HOUR OF DEATH <b>4/30/68</b>   <b>8:30 p.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b> <b>43</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>122 West Lee St.</b>	
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/15/87</b>	9. AGE (In years lost birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-03-3294</b>		17. INFORMANT <b>Hospital Records</b>	
18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>AD ARTERIOSCLEROTIC CARDIOVASCULAR Disease 5 yrs</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>AD ARTERIOSCLEROTIC CARDIOVASCULAR Disease 5 yrs</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>FRACTURE OF LEFT HUMERUS (OPEN REDUCTION 1/10/68)</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>30 April</b> 19 <b>68</b> to <b>30 April</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>30 April</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ira L. Fetterhoff M.D.</b>				23B. DATE SIGNED <b>5 MAY 68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ira. L. Fetterhoff, M.D.</b>				23D. ADDRESS <b>1300 Light St., Baltimore, 30</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>5/8/68</b>	24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Mem.</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairburn</b>		25C. FUNERAL DIRECTOR <b>Kirshley Funeral Home</b>	





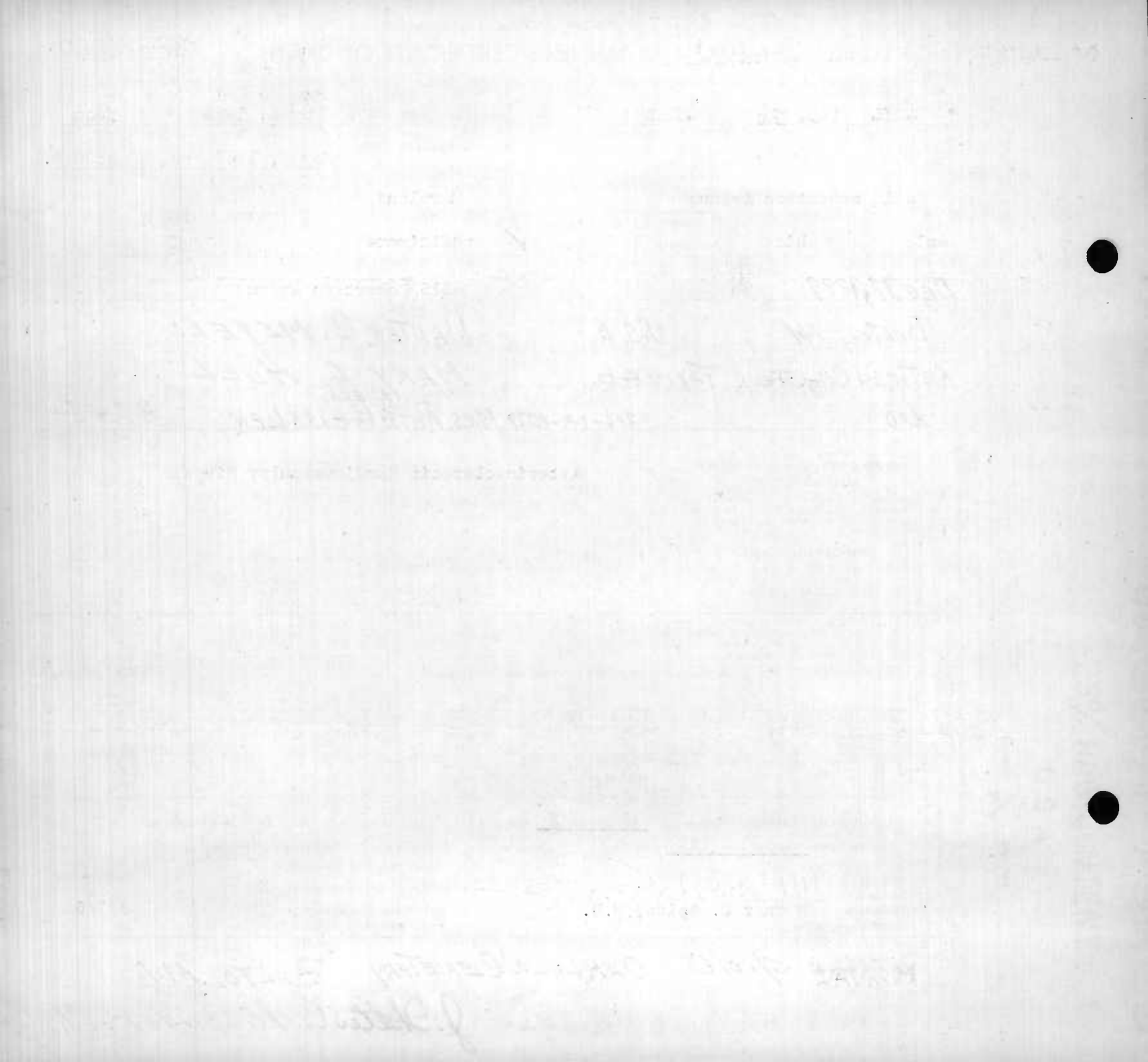
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4887

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CECIL <u>WALTER</u> MYERS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> May 6, 1968 Hour Noon M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4315 Robertson Avenue</u>		3. DATE PRONOUNCED DEAD Month Day Year Hour May 6, 1968 4:00 P.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH <u>DEC 17, 1899</u>		10. AGE (In years lost birthday) 68	
11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u>		12. CITIZEN OF <u>U.S.A.</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CHAUFFEUR TAXICAB.</u>		14B. KIND OF BUSINESS OR INDUSTRY <u>TAXICAB.</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		17. SOCIAL SECURITY NO. <u>316-03-1273</u>	
15. FATHER'S NAME <u>WALTER C. MEYERS</u>		15. MOTHER'S MAIDEN NAME <u>MARY A. HULL</u>	
18. INFORMANT <u>MRS. RUTH GEISLER</u>		ADDRESS <u>SAME</u>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 5/7/68 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/10/68</u>	
24C. NAME OF CEMETERY or CREMATORY <u>OAKLAWN CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>	
25C. FUNERAL DIRECTOR <u>J. Walter Conklin</u>		ADDRESS <u>5444 BELAIR RD.</u>	



1  
L-15-2

68- 4888 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 4888

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>RAYMOND LEVINSKI</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 4, 1968</b> 4:05 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1232 N. Caroline Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 4, 1968</b> 4:05 P. M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>June 6, 1908</b>		10. AGE (In years last birthday) <b>59</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		15. MOTHER'S MAIDEN NAME <b>Frances ?</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>216-20-5754</b>	
18. INFORMANT (Brother) <b>Mr. Henry J. Levinski, 1232 N. Caroline St.</b>		ADDRESS Balto. Md.	
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>5-5-68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>	
25C. FUNERAL DIRECTOR <b>John J. Duda, 2829 Hudson St. Balto. Md.</b>		ADDRESS	

WALTER D. BROWN  
WALTER D. BROWN  
WALTER D. BROWN

WALTER D. BROWN

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4889			
1. NAME OF DECEASED (Type or Print) <b>FRANCES V. CHILCOAT</b>				2. DATE AND HOUR OF DEATH <b>5/6/68 4:50 P.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Union Memorial Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>				53-00			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hosp.</b>				C. CITY OR TOWN <b>Perry Hall</b>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>Snyder Ave. 21228</b>											
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/12/3</b>		9. AGE (In years lost birthday) <b>64</b>		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>William Tampsett</b>				14. MOTHER'S MAIDEN NAME <b>JENNIE TAMPSETT</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-14-1394</b>		17. INFORMANT <b>Son Russell Chilcoat Snyder Avenue</b>				ADDRESS <b>Perry Hall 21128</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>398X I</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Congestive heart failure rheumatic heart disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>46X II</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) <b>Dr. Yen</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>4/20</b> 19 <b>68</b> to <b>5/6</b> 19 <b>68</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>5/6</b> 19 <b>68</b> and that in (my) ( <del>was</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
23A. SIGNATURE <b>W. H. Oehlert Jr. MD.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>5/6/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM H. OEHLERT JR. MD.</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-9-1968</b>		24C. NAME of CEMETERY or CREMATORY <b>Camp Chapel Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Co. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Jarboe</b>				25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7501 Belair 2 12</b>			

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2/10

W. H. Bell  
1/10

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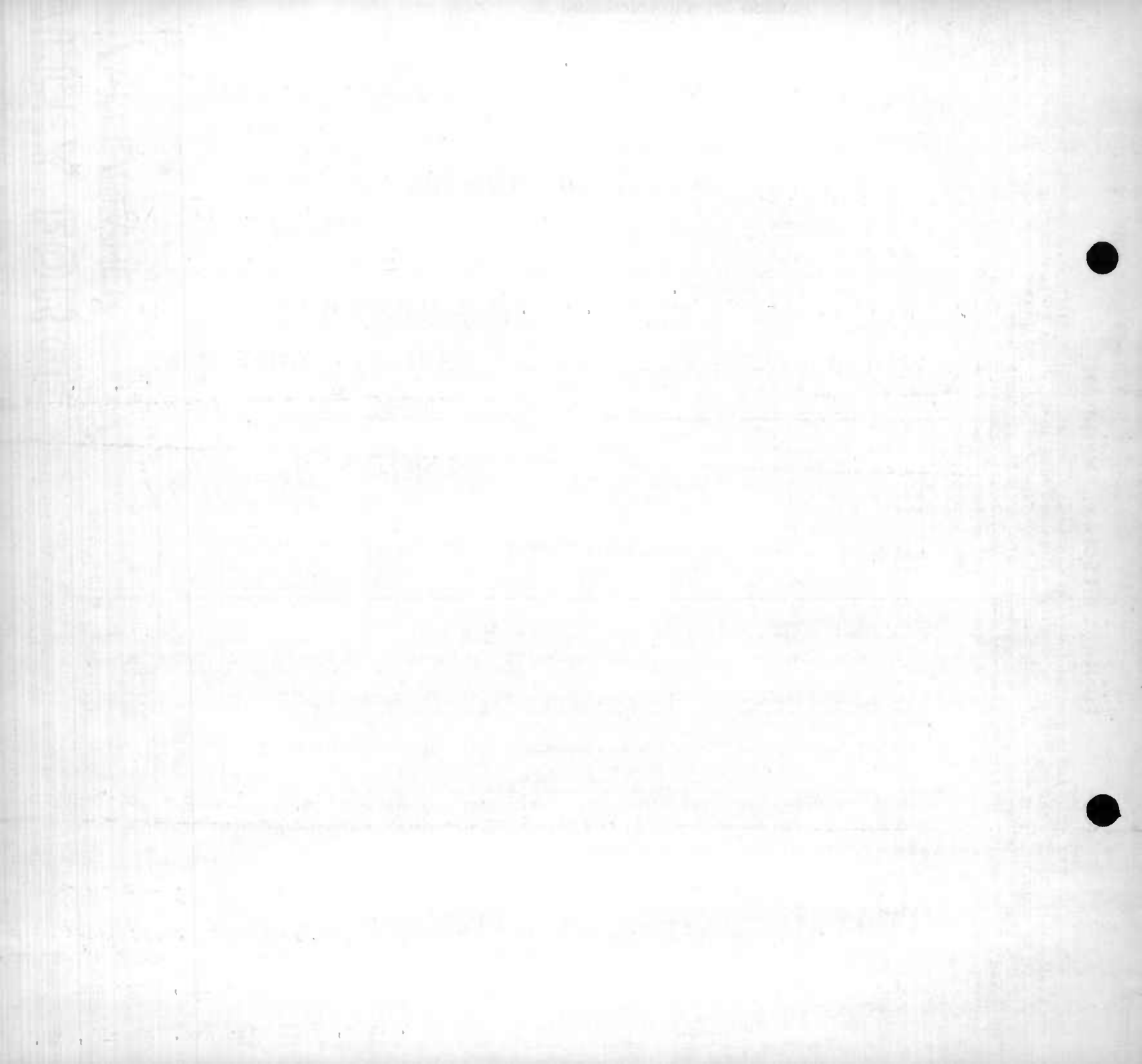
AT 52 H. A.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">86313</span>
68- 4890 CERTIFICATE OF DEATH				68- 4890
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">David W. Lee</span>		
2. DATE AND HOUR OF DEATH		<span style="font-size: 1.2em;">May 8, 1968</span>   <span style="font-size: 1.2em;">9:40 P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">36 Franklin Square Hospital</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">Edgemere</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <span style="font-size: 1.2em;">Male</span> 6. RACE <span style="font-size: 1.2em;">White</span>		E. STREET AND NUMBER <span style="font-size: 1.2em;">6904 Northpoint Rd.</span>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">2-5-1896</span> 9. AGE (In years last birthday) <span style="font-size: 1.2em;">72</span>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired - Mechanical Maint. Beth. Steel</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. A</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">William Lee</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Anna Dennis</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <span style="font-size: 1.2em;">WWI</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-07-6286</span>		17. INFORMANT (Wife) <span style="font-size: 1.2em;">Ruth L. LEE</span> ADDRESS <span style="font-size: 1.2em;">Edgemere, Md. 6904 Northpoint Rd.</span>		
18. <span style="font-size: 1.2em;">199.0</span> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">CARCINOMATOSIS TERMINAL STAGE</span>		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. <span style="font-size: 1.2em;">199.2</span> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">6:10 PM, 5-8-1968</span> to <span style="font-size: 1.2em;">9:40 PM, 5-8-1968</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">9:40 PM, 5-8-1968</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.2em;">Hyung K. Lee, M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">5-8-1968</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Hyung Kon Lee, M.D.</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">5/13/68</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Oak Lawn Cemetery</span>
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 10 1968</span>		
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Jackson</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">John J. Duda, 7922 Wise Ave. Dundalk, Md.</span>		





Medical Examiner, Case released to hospital on Approval

FUNERAL DIRECTOR: IMPORTANT

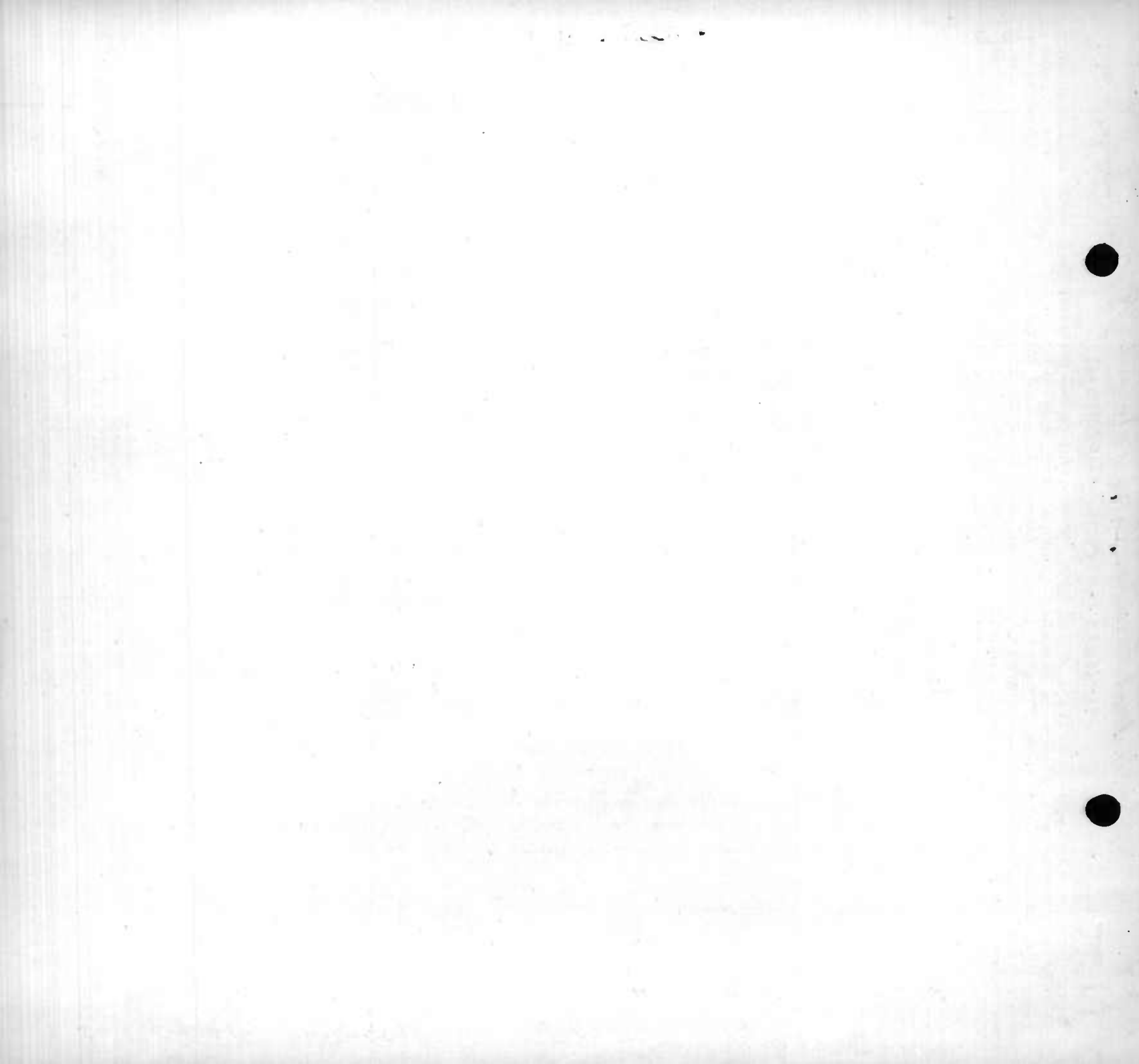
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68-4891 CERTIFICATE OF DEATH

REG. NO.

68-4891

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CLARA TRENTON		5/7/68 1:50 PM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
MARYLAND General Hospital				MARYLAND BALTIMORE	
48				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
2025 Wells Manor					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/11/02	65	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired			West Virginia		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Sambard G. Beach			Benson Haver		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			86-01-9845B		Mrs Ellis Tucker NA.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Pulmonary Embolism massive		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			Fracture Neck @ Femur		
2904.0 II			4/29/68		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
5/6/68		Fracture Neck @ Femur		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input checked="" type="checkbox"/>		@ hip		home Basement 53-00	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
April 29 '68 7:30 PM		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		Came Slipped & Lost balance	
22. I certify that (I) (this hospital) attended the deceased from May 4, 1968 to May 7, 1968, that (I) (we) last saw the deceased alive on 5/7/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Hector G. Martinez				May 7, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Hector G. Martinez				26 Acorn Circle Apt. 302 Towson, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/11/68		LAMMANSVILLE	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 10 1968		R. E. Taylor		Stanbury F. Home	

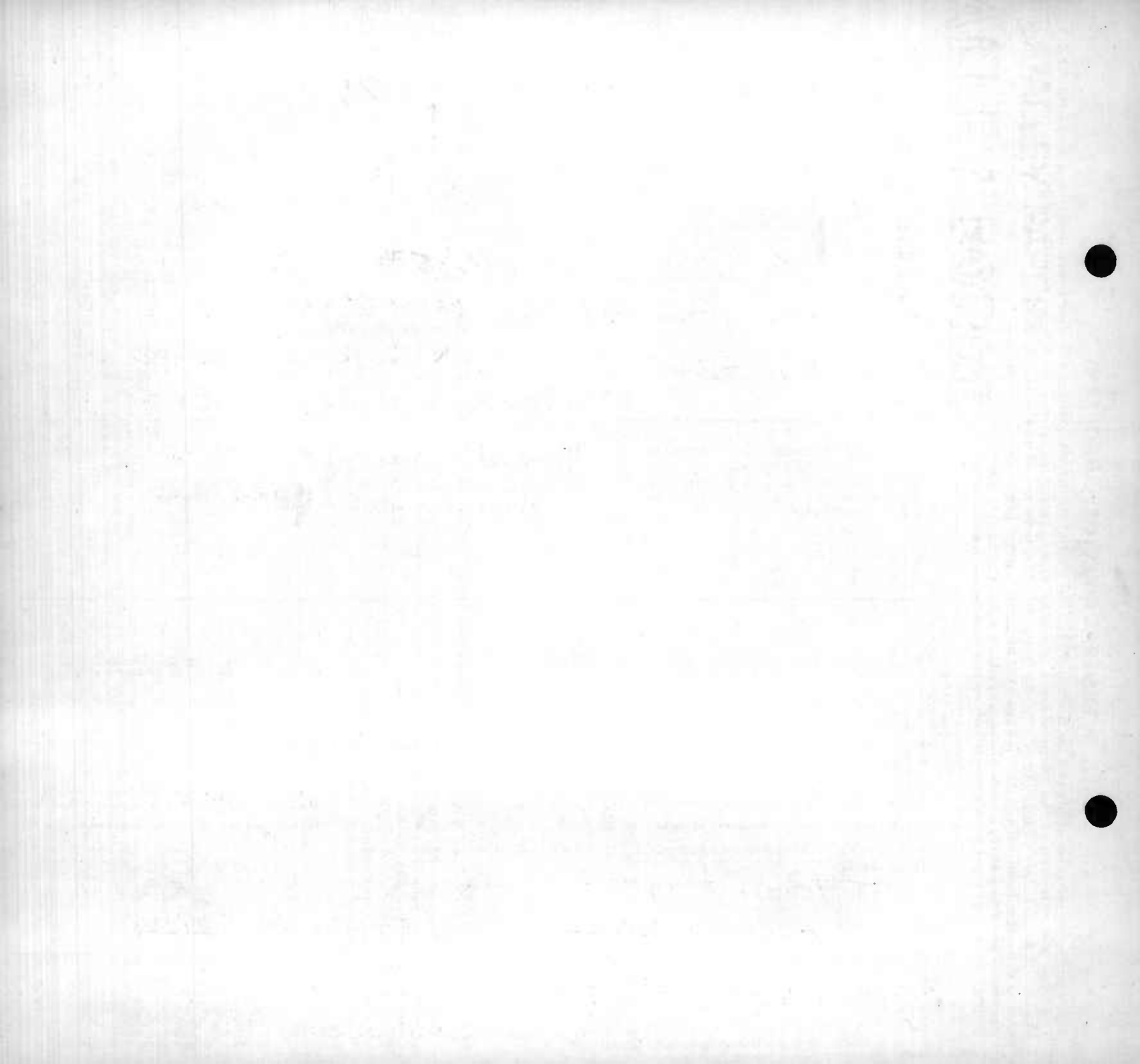


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 4892 CERTIFICATE OF DEATH

REG. NO. 68-4892

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>LOUVENIA E. Laveille</u>		2. DATE AND HOUR OF DEATH <u>5/9/68</u> @ <u>12:06</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Good Convalescent Home</u> <u>90313 Edmondson Ave</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>	
5. SEX <u>F.</u>		6. RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>German Arch Home</u>		8. DATE OF BIRTH <u>11/22/96</u>	
11. BIRTHPLACE (State or foreign country) <u>CALVERT CO. MD.</u>		9. AGE (In years last birthday) <u>71</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Laveille, JAMES B.</u>				14. MOTHER'S MAIDEN NAME <u>KLINFELTER, SUSAN K.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-30-8890</u>		17. INFORMANT <u>VERA E. RITENOUR</u>	
18. I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Terminal phase of</u> <u>Adenocarcinoma of U. Bladder</u>		<u>months</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
18. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/29/68</u> to <u>5/8/68</u> , that (I) (we) last saw the deceased alive on <u>5/8/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Adnan M. Sonmez</u>				23B. DATE SIGNED <u>5/9/1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>ADNAN M. SONMEZ</u>				23D. ADDRESS <u>1011 Frederick Rd. 21228</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/11/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>ST PAUL</u>	
24D. LOCATION (City, town, or county) <u>LUSBY CALVERT CO. MD</u>		24E. (State) <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>J.T. STANSBURY</u>	
				ADDRESS <u>6411 WINDSOR MILL RD. BALTO MD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4893

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68-4893

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HOWARD BERTRAND</b>		2. DATE AND HOUR OF DEATH <b>5/7/68</b>   <b>7:50 AM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6910 Gough St.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/27/11</b>	9. AGE (In years last birthday) <b>56</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>City of Balto.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>JOHN H. BERTRAND</b>			14. MOTHER'S MAIDEN NAME <b>BARBARA KUZEL</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>217-05-9770</b>		17. INFORMANT ADDRESS <b>Margaret E. Lehr - 830 Union Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>150X I METASTATIC CARCINOMA OF ESOPHAGUS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8/67 Discarded</b>		
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>150X II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>he</del> (this hospital) attended the deceased from <b>August</b> 19 <b>67</b> to <b>May 7</b> 19 <b>68</b> , that <del>he</del> (we) last saw the deceased alive on <b>May 7</b> 19 <b>68</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marvin C. Mengel M.D.</b>				23B. DATE SIGNED <b>5/7/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARVIN C. MENGEL M.D.</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <b>Austin E. Donovan-3818 Roland Ave.</b>	

**MAY 10 1968** **Robert E. Taylor**

DATE: 10/10/50

BY: J. H. H.

W. H. H.

RECEIVED  
JAN 10 1951

NO

10

10

10

10



FUNERAL DIRECTOR: IMPORTANT

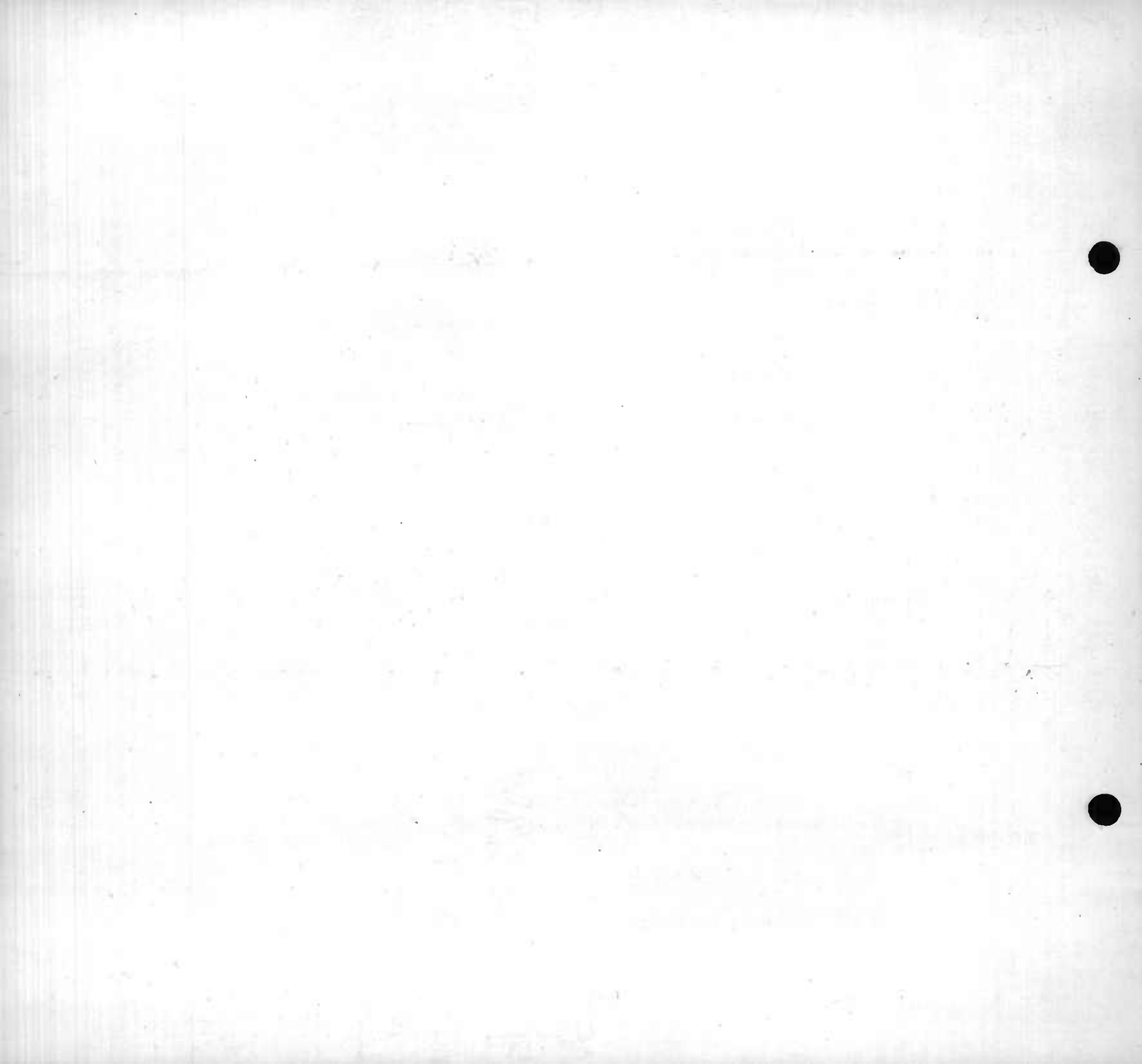
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4894

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

68- 4894  
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANNABELLE A. KLOESS		5/8/68 3 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital.				A. STATE MARYLAND	
				B. COUNTY	
5. SEX Female				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. RACE W.				E. STREET AND NUMBER 5621 Readdy Ave	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 6/24/97		9. AGE (In years last birthday) 70	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis High Smith				14. MOTHER'S MAIDEN NAME Magnolia Cardley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 219-32-1252		17. INFORMANT John A. Kloess (Wife) Same	
				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 157.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH D. Pulmonary emboli? Cerebral insufficiency, B. congestive heart failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of pancreas (B) DUE TO, OR AS A CONSEQUENCE OF: Aortic Aneurysm (C) A.S.C.V.D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 13-7X II					
19A. DATE OF OPERATION 4/17/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/4 19 68 to 5/8 19 68, that (I) (we) last saw the deceased alive on 5/8 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cyrus Makowi				23B. DATE SIGNED 5/8/68	
23C. PHYSICIAN'S NAME (Type) CYRUS MAKOWI				23D. ADDRESS Md. Gen. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/11/1968		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1968		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 21212	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68-- 4895

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CORRALL, MARIA ROSEA</b>		2. DATE AND HOUR OF DEATH <b>MAY 7, 1968</b>		12:20 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVES. BALTIMORE, MARYLAND 21229</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21227 Balt. Co. 53-00</b> C. CITY OR TOWN <b>Lansdowne</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2403 BRUNSWICK RD.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-18-1885</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. FATHER'S NAME <b>ANTHONY Motore</b>				14. MOTHER'S MAIDEN NAME <b>( Unknown )</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CATON &amp; WILKENS ST. AGNES HOSP. RECORDS-BALTO., MD.</b>			
18. <b>427.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Arrest</b> (B) <b>Congestive Cardiac Failure</b> (C) _____			
19. <b>434.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <b>APRIL 24</b> 19 <b>68</b> to <b>MAY 7</b> 19 <b>68</b> , that (X) (we) last saw the deceased alive on <b>MAY 7</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Victor A. Albers</b>				23B. DATE SIGNED <b>5-7-1968</b>		23C. PHYSICIAN'S NAME (Type) <b>VICTOR A. ALBERS</b>	
23D. ADDRESS <b>CATON &amp; WILKENS AVES.-BALTO., MD. 21229</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					
24B. DATE <b>5-10-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Davis Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Davis, West Virginia</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		25D. ADDRESS <b>4107 Wilkens Ave. 21229</b>			

Corporate Capital  
Capital Growth

Walt Disney

Walt Disney

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">68-4896</span>
1. NAME OF DECEASED (Type or Print) <b>JOHN RUTHKE JR</b>		2. DATE AND HOUR OF DEATH <b>8 MAY 68</b> <span style="float: right;"><b>10:35 A.M.</b></span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> <span style="float: right;"><b>53-00</b></span>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE 21234</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> <span style="float: right;">?</span>
		E. STREET AND NUMBER <b>6805 COLLINGSDALE RD.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-13-15</b>	9. AGE (In years last birthday) <b>52</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BAKER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN RUTHKE</b>		
14. MOTHER'S MAIDEN NAME <b>ROSE NICK</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b> <b>NW TWO</b>		
16. SOCIAL SECURITY NO. <b>?213-05427</b>		17. INFORMANT <b>CHART</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>HEPATIC COMA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) <b>CIRRHOSIS &amp; GI</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>BLEEDING</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>581.0 II</b>		<b>Cerebro-Vascular Accident</b>		
19A. DATE OF OPERATION <b>JAN 68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PORTAL CAVEN SHUNT - PORTAL HYPERT</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>7 May</b> 19 <b>68</b> to <b>8 May</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8 May</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Sidney Stapleton, Jr, MD</b>		23B. DATE SIGNED <b>8 May 68</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>SIDNEY STAPLETON, JR MD</b>		23D. ADDRESS <b>Maryland General Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5-11-68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Rosaline Valley</b>	24D. LOCATION (City, town, or county) (State) <b>Cockeysville Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	25C. FUNERAL DIRECTOR <b>Wm Cook - Brooks Towne</b> <span style="float: right;">1050 York Road Towson, Md. 21204.</span>		

WORKING GENERAL REPORT

W. M. X

BAKER

JOHN BAKER

1st

BAKER

HEALTHY COME

ORDERED 1st

ORDERING

1st 1st WORKING GENERAL REPORT

1st 1st

1st

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1st 1st

1st 1st

68- 4897

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4897

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY C. MORSBERGER

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

5

7

68

2:50 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1913 Breitwert Ave.

3. DATE  
PRONOUNCED DEAD

May

7

1968

2:50 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

3/31/1892

10. AGE (In years  
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1913 Breitwert Ave.

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Morsberger

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Painter

14B. KIND OF BUSINESS OR INDUSTRY

Painters Local 1 Union

15. MOTHER'S MAIDEN NAME

Eda Peregoy

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

213-12-0539A

18. INFORMANT

Mr John Morsberger

ADDRESS

8427 Old Harbor Rd.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

No

22D. TIME  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/8/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5/9/68

24C. NAME OF CEMETERY or CREMATORY

Green Haven Cem.

24D. LOCATION

Ritchie Hwy Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT

MAY 10 1968

25B. NAME OF REGISTRAR

Robert E. Finken

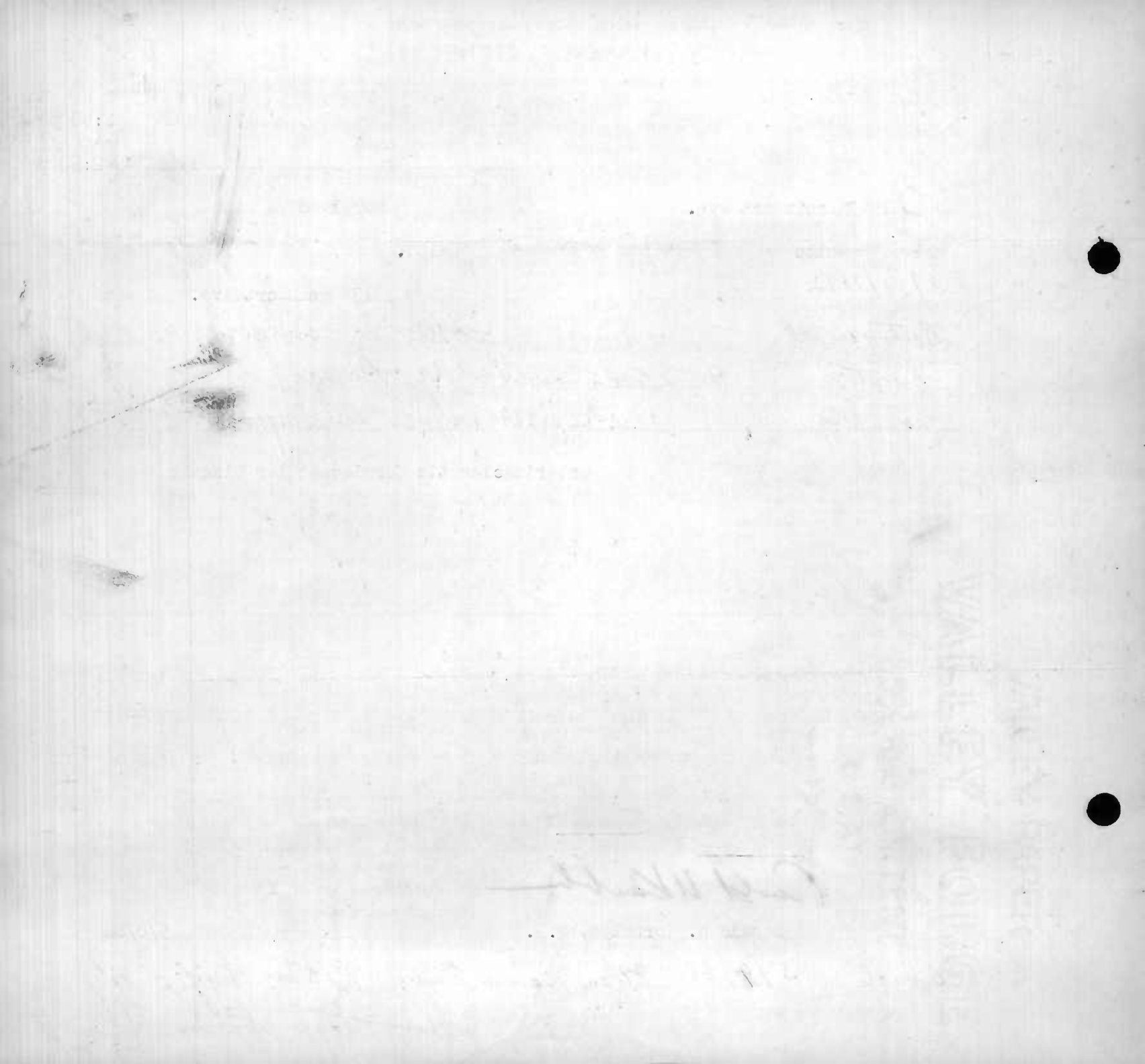
25C. FUNERAL DIRECTOR

John J. Cowan + Son Inc. Hollins St.

ADDRESS

23. Md.

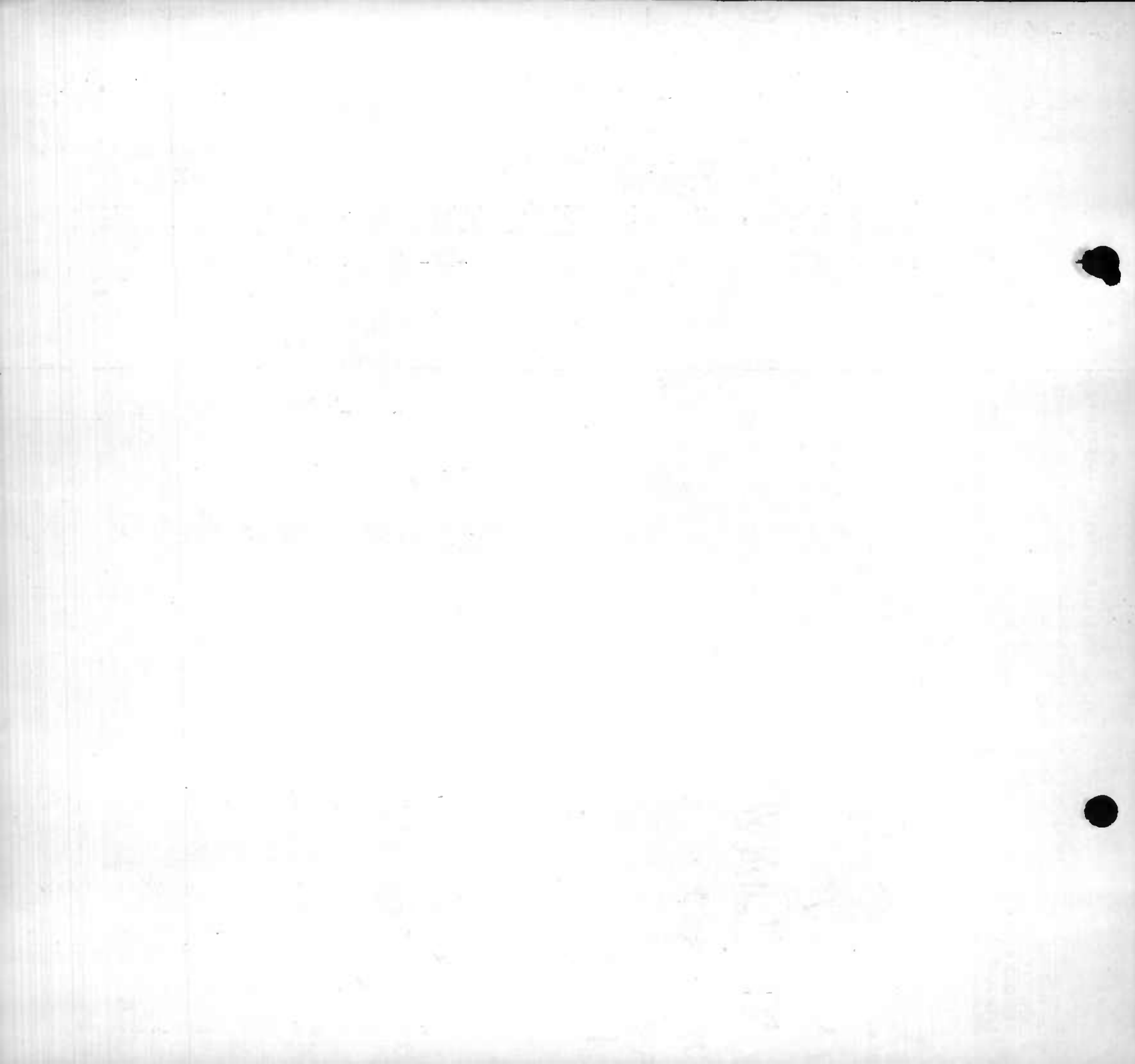




## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Schwartz, John</b>		2. DATE AND HOUR OF DEATH <b>5/13/68 11 55 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>				A. STATE <b>MARYLAND</b> B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>4940 EASTERN AVENUE</b>				#21224	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>7-12-92</b>	9. AGE (In years lost birthday) <b>75</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>Schwartz</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME <b>unknown</b>	
16. SOCIAL SECURITY NO.				17. INFORMANT <b>RECORDS-BCH-4940 EASTERN AVENUE</b>	
18. <b>199.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>UNDIFFERENTIATED ADENOCARCINOMA 3 yr.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yr.</b>	
19. <b>199.2 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>BPH</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>19 Feb 1966</b> to <b>3 May 1968</b> , that (1) (we) last saw the deceased alive on <b>3 May 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Melvyn S. Tockman MD</b>				23B. DATE SIGNED <b>3 May 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. MELVYN S. TOCKMAN</b>				23D. ADDRESS <b>BCH-4940 EASTERN AVENUE, BALTIMORE, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-9-1968</b>		24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. STATE <b>Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jarboe</b>		25C. FUNERAL DIRECTOR <b>Walter Dabrowski</b>	
25D. ADDRESS <b>1005 Dundalk Avenue</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

NUN - MED - DR. KERN BLUM

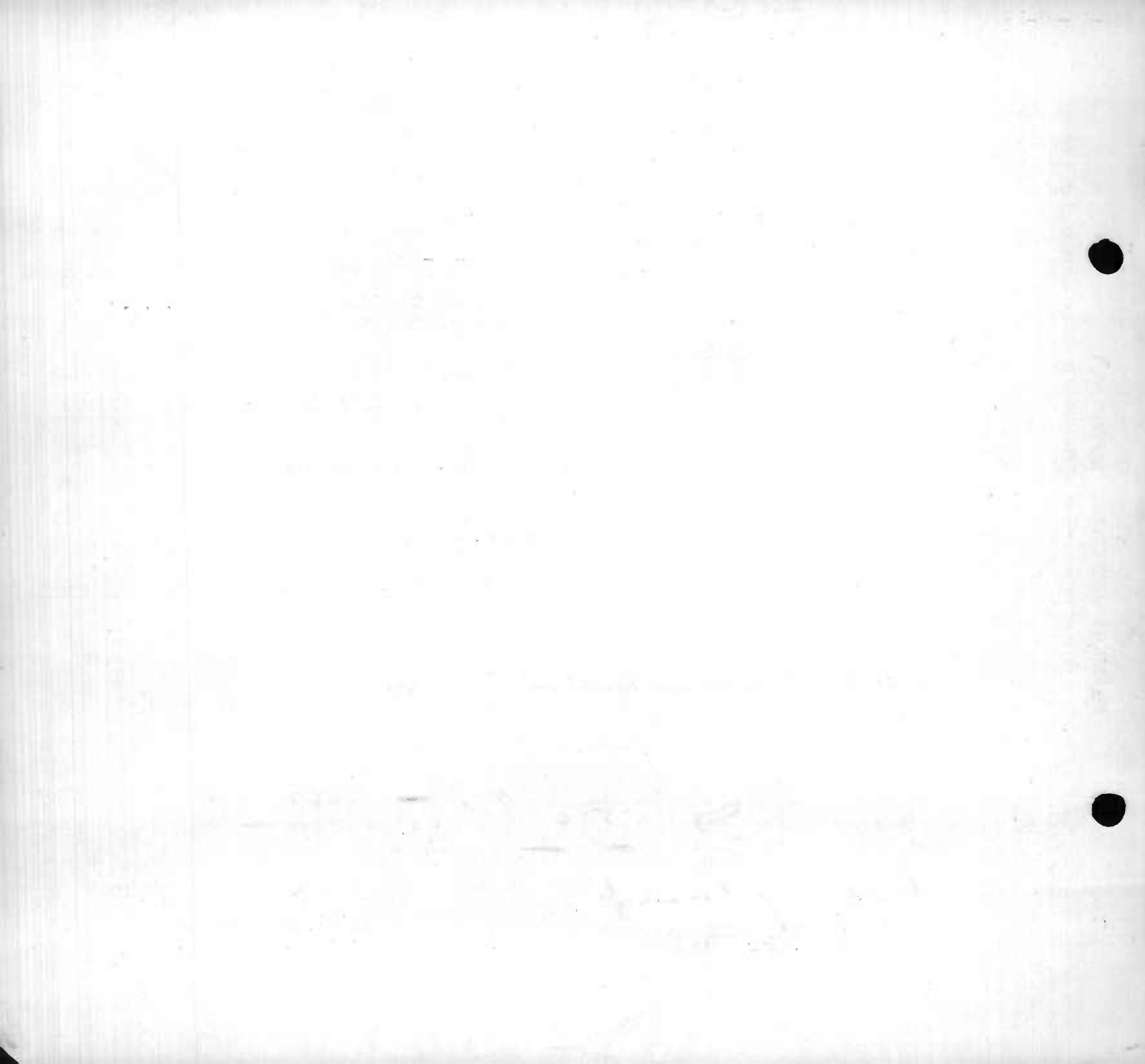
BALTIMORE CITY HEALTH DEPARTMENT									
5-530 68- 4899 CERTIFICATE OF DEATH									
REG. NO. 68- 4899									
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SMITH, ROSA L</b>				2. DATE AND HOUR OF DEATH <b>5/8/68 4 05 P</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER <b>1617 ENSOR ST.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-9-02</b>		9. AGE (In years last birthday) <b>65</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>OSCAR TAYLOR</b>				14. MOTHER'S MAIDEN NAME <b>MARY HOPKINS</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>246-09-3227</b>		17. INFORMANT <b>HELEN KING 1125 ORLEANS ST</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>250.9 I</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Arteriosclerotic Cardiovascular disease.</b>				(C) <b>Diabetes mellitus with Urinary</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>260 X II</b>				Hx of previous myocardial infarction brought in D.O.A.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (my) (this hospital) attended the deceased from <b>May 8<sup>th</sup> 1968</b> to <b>May 8<sup>th</sup> 1968</b> , that (I) (we) last saw the deceased alive on <b>Brought in D.O.A.</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Richard H. Winterbauer</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>5/8/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD H. WINTERBAUER</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-12-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>NIT CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>O. O. COUNTY Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>JOSEPH KNIGHT 1639 N. BROADWAY</b>					

WOM - WEB - DR KOLMBROW

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-4900				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4900			
1. NAME OF DECEASED (Type or Print) <b>Albert. Bridges</b>				2. DATE AND HOUR OF DEATH <b>5-7-68</b> <b>6<sup>15</sup> A</b> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>				A. STATE <b>Maryland</b>				B. COUNTY			
				C. CITY OR TOWN <b>Baltimore</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <b>2751 Fenwick Avenue</b>				<b>21218</b>			
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-28-1938</b>		9. AGE (in years last birthday) <b>29</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Donald Bridges</b>				14. MOTHER'S MAIDEN NAME <b>McNeil</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records: BCH-4940 Eastern Avenue</b>				ADDRESS <b>21224</b>	
18. <b>456X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PROB. PNEUMONIA</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASPIRATION?</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>491X II</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <b>6-24-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Subdural hematoma ITH</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>5-7-68</b> <b>1967</b> to <b>5-7</b> <b>1968</b> , that (I) (we) last saw the deceased alive on <b>5-6</b> <b>1968</b> and that in (my) <b>apinlan</b> death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.											
23A. SIGNATURE <b>Dowd J. Yarborough</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>5/7/1968</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dowd J. Yarborough</b>				23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue, Baltimore, Maryland 21224</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-11-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Witcham Cul</b>		24D. LOCATION (City, town, or county) (State) <b>9-9-68 MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR <b>Choy Wilton Kimbrell</b>		ADDRESS					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68- 4901	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
MARY M. KNIGHT		MAY 7, 1968 7:30 A.M.		FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33		A. STATE B. COUNTY MARYLAND CITY OF BALTIMORE	
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN BALTIMORE	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 64		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13. FATHER'S NAME BEN COOPER		14. MOTHER'S MAIDEN NAME MARY GARRETT		E. STREET AND NUMBER 39 SOUTH DALLAS STREET			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Wendell Zuker		ADDRESS	
18. 5-75-X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST (B) ACUTE RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF: (C) HYPOTENSIVE EPISODE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 1 WEEK			
19A. DATE OF OPERATION 5-8-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED EMPHYSEMA OF GALLBLADDER		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 4/21/68 to 5/7/68 that (I) last saw the deceased alive on 5/7/68 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE Brent R. Horsley, M.D.		23B. DATE SIGNED 5/7/68		23C. PHYSICIAN'S NAME (Type) BRENT L. HORSLEY, M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5-10-68		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem		24D. LOCATION (City, town, or county) (State) A A O MD	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1968		25B. NAME OF REGISTRAR R. E. F. Adams		25C. FUNERAL DIRECTOR Eugene Wilson		ADDRESS	



C-100

68-- 4902

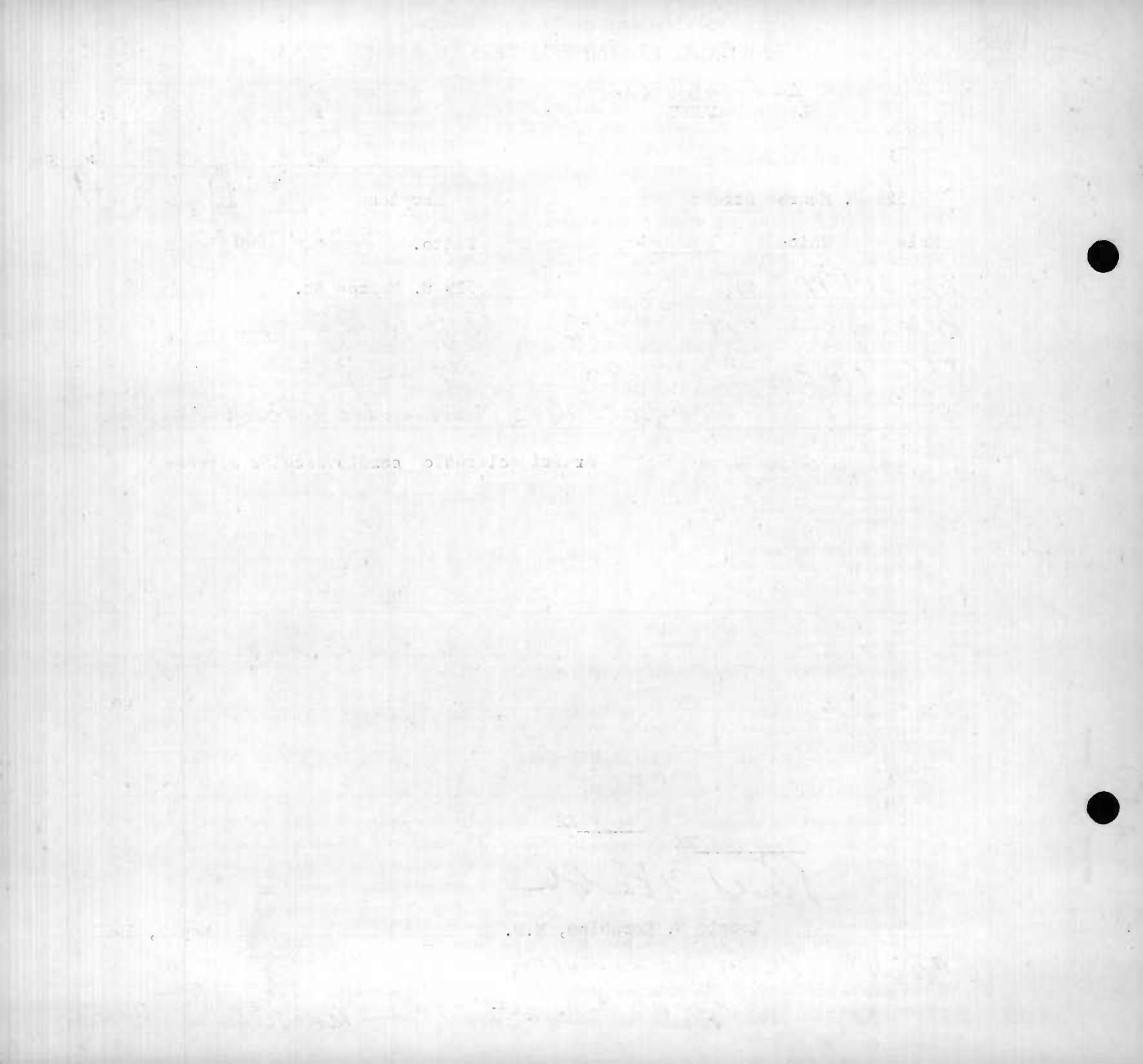
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-- 4902  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LEONARD FRANCIS CAVEY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>5</b> Day <b>9</b> Year <b>68</b> Hour <b>9:00 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 529 S. Monroe Street</b>		3. DATE PRONOUNCED DEAD Month <b>May</b> Day <b>9</b> Year <b>1968</b> Hour <b>9:00 a.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto. 21223</b>	
9. DATE OF BIRTH <b>May 23-1899</b>		10. AGE (In years last birthday) <b>69</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Geo. R. P. Engineer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>BORR</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>705-05-3692</b>		17. SOCIAL SECURITY NO. <b>705-05-3692</b>	
13. FATHER'S NAME <b>Art R. Cavey</b>		15. MOTHER'S MAIDEN NAME <b>Agnes ?</b>	
18. INFORMANT <b>Marcella L. Fletcher (Daughter)</b>		ADDRESS <b>Same</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>422.1 II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) <b>no</b>	
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>None</b>		24B. DATE <b>May 13-1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Linden Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>CURTIS E. EVANS</b>		ADDRESS <b>14005 Charles 21230</b>	



M 255

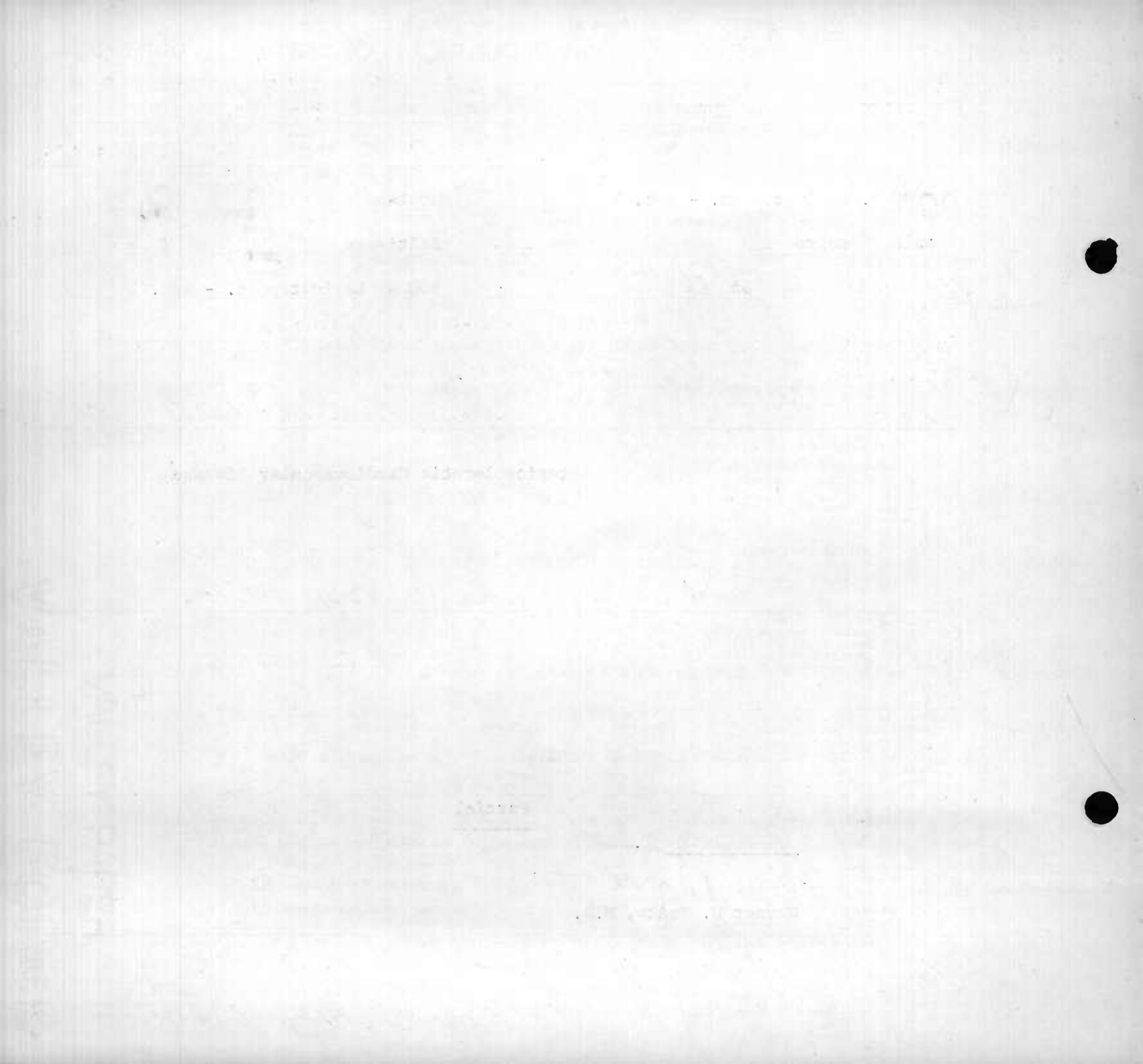
68-- 4903

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-- 4903

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>EDDIE MCKINNON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>May 2, 1968</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>900 W. Lexington St. - Apt. 1</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 6, 1968 5:25 P.</b> M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>18-01</b>	
9. DATE OF BIRTH <b>FEB. 10. 1902</b>		10. AGE (In years lost birthday) <b>65 66</b>	
11. BIRTHPLACE (State or foreign country) <b>Rowland N.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ARCHIE MCKINNON</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		16. KIND OF BUSINESS OR INDUSTRY <b>CONTRACTOR</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO.	
19. <b>412.41</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>422.1 II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Partial Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spatz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5/7/68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mount Airy</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Spatz</b>	
25C. FUNERAL DIRECTOR <b>James E. P. Spatz</b>		ADDRESS <b>635 W. Guilford St</b>	

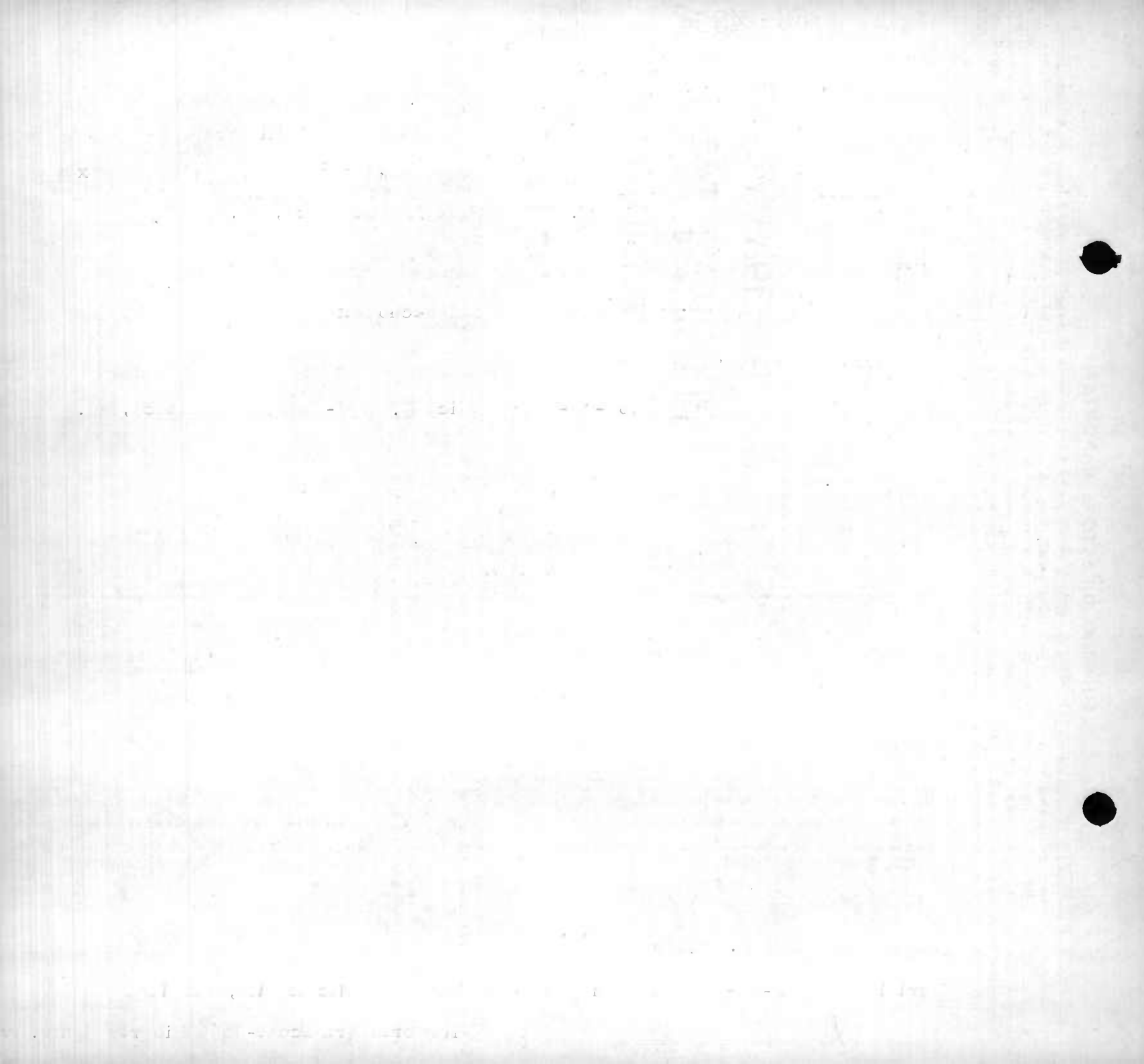


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4904	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Boyd, Raymond H.</b>		2. DATE AND HOUR OF DEATH <b>May 7th 1968</b>   <b>11: 15</b> AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Saint Agnes Hospital Caton &amp; Wilkens Aves. 40 21229</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> 8. COUNTY <b>Baltimore</b> <b>53-00</b> C. CITY OR TOWN <b>Woodstock</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Box 91 Woodstock, Md.</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/1/10</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>C.R. Daniels</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	
13. FATHER'S NAME <b>Harry Boyd</b>		14. MOTHER'S MAIDEN NAME <b>Dyson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>461-20-2592</b>		17. INFORMANT ADDRESS <b>Alice F. Boyd-Box 91 Woodstock, Md.</b>	
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac failure</b> (B) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Arteriosclerosis</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>420.1 II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1957</b> 19 to <b>17 May</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7 May</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William J. Bryson</b> M.D. DEGREE				23B. DATE SIGNED <b>9 May 68</b>	
23C. PHYSICIAN'S NAME (Type) <b>William J. Bryson</b>				23D. ADDRESS <b>4605 Edmondson ave</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-11-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Good Sheperd Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Ellicott City, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Ellsworth Armacost-4600 Liberty Hghts. Av</b>			





S-530

68- 4905 BALTIMORE CITY HEALTH DEPARTMENT

68- 4905

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>LEO</b> <b>SLYVESTER</b> <b>SMITH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month <b>May</b> Day <b>6</b> Year <b>1968</b> Estimated <input type="checkbox"/> <b>10:30 A</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2520 E. Preston Street</b>		3. DATE PRONOUNCED DEAD Month <b>May</b> Day <b>6</b> Year <b>1968</b> <b>10:30 A</b> M.	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Aug 26, 1945</b>		10. AGE (In years last birthday) <b>22</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Bald. Md</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>George W. Smith</b>		ADDRESS	
19. <b>3049 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Intravenous Narcotism</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>323 X</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bronchopneumonia</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5-6-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>May 10 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Grav DeBure Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Wattson Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltner</b>	
25C. FUNERAL DIRECTOR <b>Frank T. Elicker</b>		ADDRESS <b>11297 Indigo</b>	

George W. Smith  
John Williams  
George W. Smith

George W. Smith  
John Williams  
George W. Smith

George W. Smith  
John Williams  
George W. Smith

George W. Smith  
John Williams  
George W. Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Miller, James S. 128837x

460		68-- 4906		BALTIMORE CITY HEALTH DEPARTMENT		68-- 4906	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.	
		MILLER, JAMES		5/7/68		11 35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND, BALTIMORE CITY			
33				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				1907 ASHLAND AVENUE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months	11. UNDER 24 Hrs. Hours	12. CITIZEN OF WHAT COUNTRY?
MALE	NEGRO	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11-13-87	80			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Clergy						Va.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
FELIX MILLER				BETSY CRAWLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						Gloria Anderson 1907 Ashland Ave.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Cardiac Arrest			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				Myocardial Infarction			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 5/7/68 19 to 5/7/68 19, that (I) (we) last saw the deceased alive on 5/7 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Philip Reid M.D.				5/7/68			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
PHILIP REID, M.D.				JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Removal May 10/68						Farmville Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 10 1968		Robert E. Farber		Gladys C. Cline		129 N. Carroll St	

WIRY... 12-13-83

THE... HOSPITAL BATTING

1707 ASHMAN AVE

11-13-83

MAKE NEED



BETSY CRAWLEY

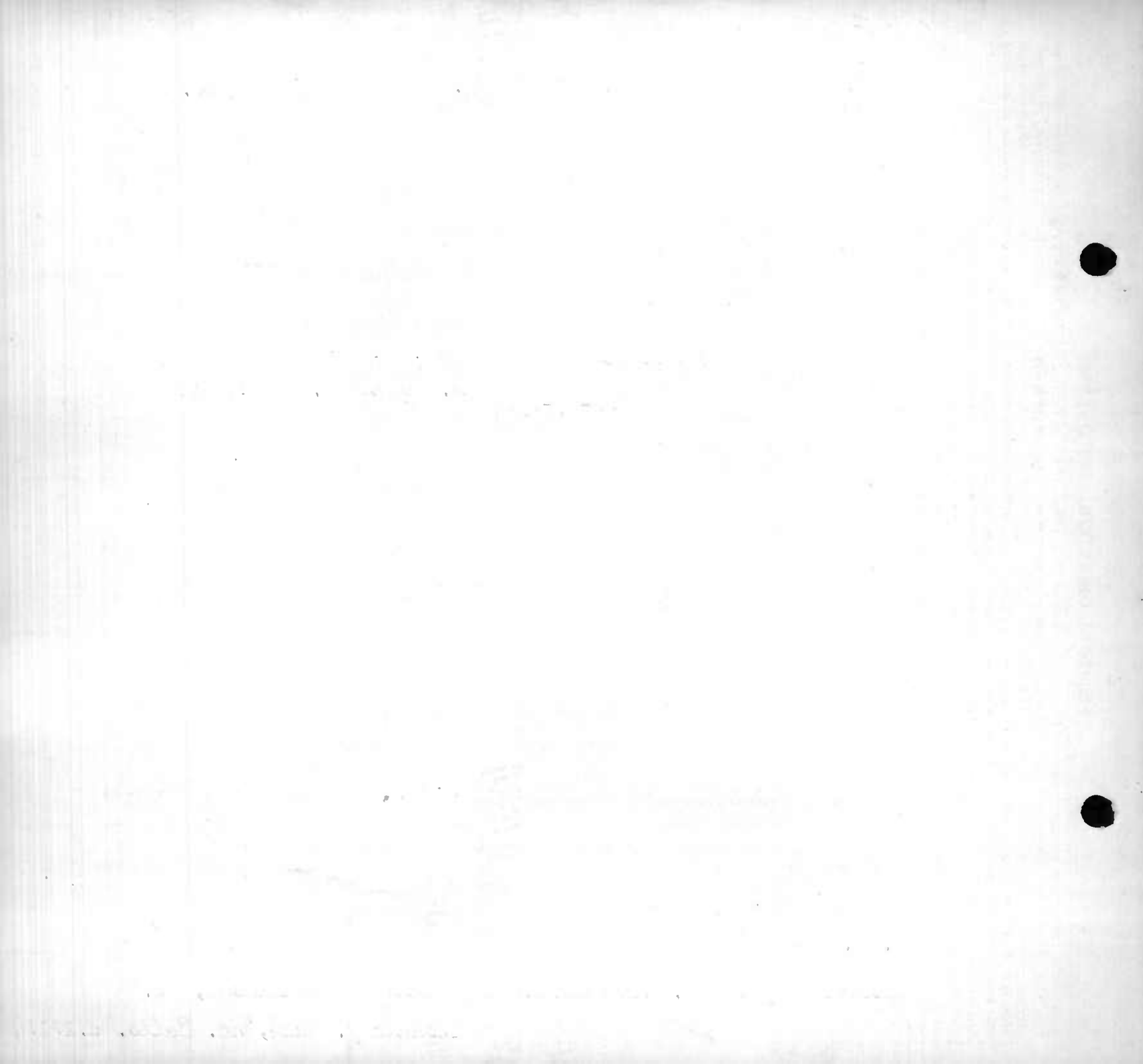
FELIX WILKIN

PHILIP REID M.D. JOHN HOPKINS HOSPITAL

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4907	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 2em;">B-363</span> <span>68- 4907</span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <i>Batterden, Margaret E.</i>		2. DATE AND HOUR OF DEATH <i>5/9/68. 11:55 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hosp.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Md.</i> B. COUNTY <i>Balt. City</i>	
C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>1538 Palworth Road</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/27/07</i>	9. AGE (In years last birthday) <i>60</i>	10. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Ratcliffe; Plummer</i>		14. MOTHER'S MAIDEN NAME <i>Anna E. Laudenschleger</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>216-09-8584</i>		17. INFORMANT <i>Mr. Robert J. Batterden</i>		ADDRESS <i>Same</i>	
18. <i>174X I</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Ca of breast - metastases</i>			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
170X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/9/68</i> to <i>5/9/68</i> and that (I) (we) last saw the deceased alive on <i>5/9/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>B. J. Weckesser</i>		23B. DATE SIGNED <i>5/9/68</i>			
23C. PHYSICIAN'S NAME (Type) <i>B. J. Weckesser</i>		23D. ADDRESS <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/13/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1968</i>		24F. NAME OF REGISTRAR <i>Robert E. Fisher</i>	
24G. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1968</i>		24H. NAME OF REGISTRAR <i>Robert E. Fisher</i>		24I. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>	
24J. ADDRESS <i>Balto. Md. 21214</i>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-- 4908	
P-362 68-- 4908		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Susie Peterson</i>		2. DATE AND HOUR OF DEATH <i>5/7/68 11:35 P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 4027 Rogers Ave.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>4 Oct 1900</i>		9. AGE (In years last birthday) <i>68</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Marion Alabama</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Minns Graham</i>		14. MOTHER'S MAIDEN NAME <i>Clark Reed</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>420-18-1791</i>		17. INFORMANT <i>Mr. Moses Peterson, Sr.</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Myocardial Infarction Immediate</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Cardiovascular Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>420.1 II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 67</i> 19 to <i>5/7</i> 1968, that (I) (we) last saw the deceased alive on <i>5/7/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Carlton I. Halle</i>		23B. DATE SIGNED <i>5/7/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Carlton I. Halle</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-11-68</i>		24C. NAME of CEMETERY or CREMATORY <i>Balto. Nat'l Cem.</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>Morton E. Dyett F.H.</i>		ADDRESS <i>1701 Laurens</i>	

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

CLASSIFIED  
EXCEPT WHERE SHOWN  
OTHERWISE

EXCEPT WHERE SHOWN  
OTHERWISE

DATE 10-10-80 BY SP-10  
REASON FOR DECLASSIFICATION

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4909	
BIRTH NO. 68-4909					
1. NAME OF DECEASED (Type or Print) <b>MARTHA XBROWN</b>			2. DATE AND HOUR OF DEATH <b>5/7/68 1:30AM</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTS C.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2722 Lodge Farm Rd.</b>		
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-14-19</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic work</b>			11. BIRTHPLACE (State or foreign country) <b>Littleton, North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Turner Price</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Flaucon</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>240-54-4951</b>		17. INFORMANT <b>Mr. Albert Brown</b> ADDRESS <b>2722 Lodge Farm</b>
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ASPIRATION PNEUMONIA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>METASTATIC CARCINOMA OF THE BREAST</b> 2 years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>no</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/27</b> 19 <b>68</b> to <b>5/7/</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5/7/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John R. Stone, M.D.</b>			23B. DATE SIGNED <b>5-7-68</b>		23C. PHYSICIAN'S NAME (Type) <b>JOHN R. STONE, MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>5-11-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Grove Cem.</b>
24D. LOCATION (City, town, or county) <b>Littleton,</b>			(State) <b>N.C.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F.H.</b> ADDRESS <b>1704 Laurens</b>	

Glenn Hopkins Hospital

Room 6

Thurs. 11:00

Thurs. 11:00

Glenn Hopkins Hospital

Room 6

Thurs. 11:00

Thurs. 11:00

Thurs. 11:00

Glenn Hopkins Hospital

Room 6

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4910	
<div style="display: flex; justify-content: space-between;"> <span>5-520</span> <span>68-4910</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LURENDA JONES		5. 8. 68 7 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
46 LUTHERAN HOSPITAL OF MARYLAND			MD		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALT 170 RE		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			922 N. Baltimore St.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
F	C	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. 4. 19	48	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House wife		Home		Charlotte, N.C.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James Moore			Elizabeth Moore		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		579-14-8975		CHART	
18. CAUSE OF DEATH					
<div style="display: flex;"> <div style="flex: 1;"> <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>UREMIA</p> <p>(B) CH. PYELONEPHRITIS or DIABETIC NEPHROPATHY DUE TO, OR AS A CONSEQUENCE OF:</p> <p>DIABETES MELLITUS</p> <p>(C) HCV D - Congestive Heart Failure</p> </div> <div style="flex: 1;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
<div style="display: flex;"> <div style="flex: 1;"> <p>19A. DATE OF OPERATION</p> <p>20A. AUTOPSY? (Yes or No)</p> <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p>21D. TIME OF INJURY (APPROX.)</p> </div> <div style="flex: 1;"> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21E. INJURY OCCURRED</p> <p>21F. HOW DID INJURY OCCUR?</p> </div> <div style="flex: 1;"> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> </div> </div>					
<div style="display: flex;"> <div style="flex: 1;"> <p>22. I certify that (I) (this hospital) attended the deceased from 4. 22. 1968 to 5. 8. 1968, that (I) (we) last saw the deceased alive on 5. 8. 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.</p> </div> <div style="flex: 1;"> <p>23A. SIGNATURE</p> <p>P. Aziz</p> <p>23B. DATE SIGNED</p> <p>5. 8. 68.</p> </div> </div>					
<div style="display: flex;"> <div style="flex: 1;"> <p>23A. PHYSICIAN'S NAME (Type)</p> <p>P. Aziz</p> </div> <div style="flex: 1;"> <p>23D. ADDRESS</p> <p>LUTHERAN HOSP., BALTO. MD 21216</p> </div> </div>					
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5-13-68		Balt. Nat'l Com.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 10 1968		R. D. R. F. R. R.		Morton & Dyett F.H. 1201 Laurens	

RECEIVED  
JAN 11 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

24 11 4.2

11 11 10.1

CHART

URANIA

of PERSONNEL in GRADE 10  
DIRECTOR BUREAU  
HOLD 2 copies of report  
YES

11 11 10.1

11 11 10.1

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BEULAH ALEXANDER</b>		2. DATE AND HOUR OF DEATH <b>5. 9. 68</b>   <b>3:45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARYLAND</b> <b>46</b>			C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? <b>YES</b> <b>8-02</b>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>2114 CLIFWOOD AVE</b>		
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>9-4-1911</b>	9. AGE (In years lost birthda) <b>56</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home.</b>	11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>ANDREW Livooy</b>			14. MOTHER'S MAIDEN NAME <b>BERTRUDE FOREST</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>CHART</b>		
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HEMORRAGE / CEREBRAL THROMBOSIS / EMBOLISM</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ATRIAL FIBRILLATION</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD / Rheumatic Heart Disease</b> (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>433.1 II</b>					
19A. DATE OF OPERATION <b>08</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-8-1968</b> to <b>5-9-1968</b> , that (I) (we) last saw the deceased alive on <b>5-9-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>P. Aziz, M.D.</b>			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5. 9. 1968</b>
23C. PHYSICIAN'S NAME (Type) <b>P. Aziz, M.D.</b>			23D. ADDRESS <b>9. LUTHERAN HOSPITAL, BALTO, MD 21216</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>5/14/68</b>	24C. NAME of CEMETERY or CREMATORY <b>Mt Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore 21225</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Marshall P. Angus (387) Gibson St</b>	



with forward view

to view of

Chart

Caravan / ~~Caravan~~ / Caravan

After fixation

ACVD / ~~Caravan~~ / Caravan

2.2

2.2

2.2

Caravan / ~~Caravan~~ / Caravan

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

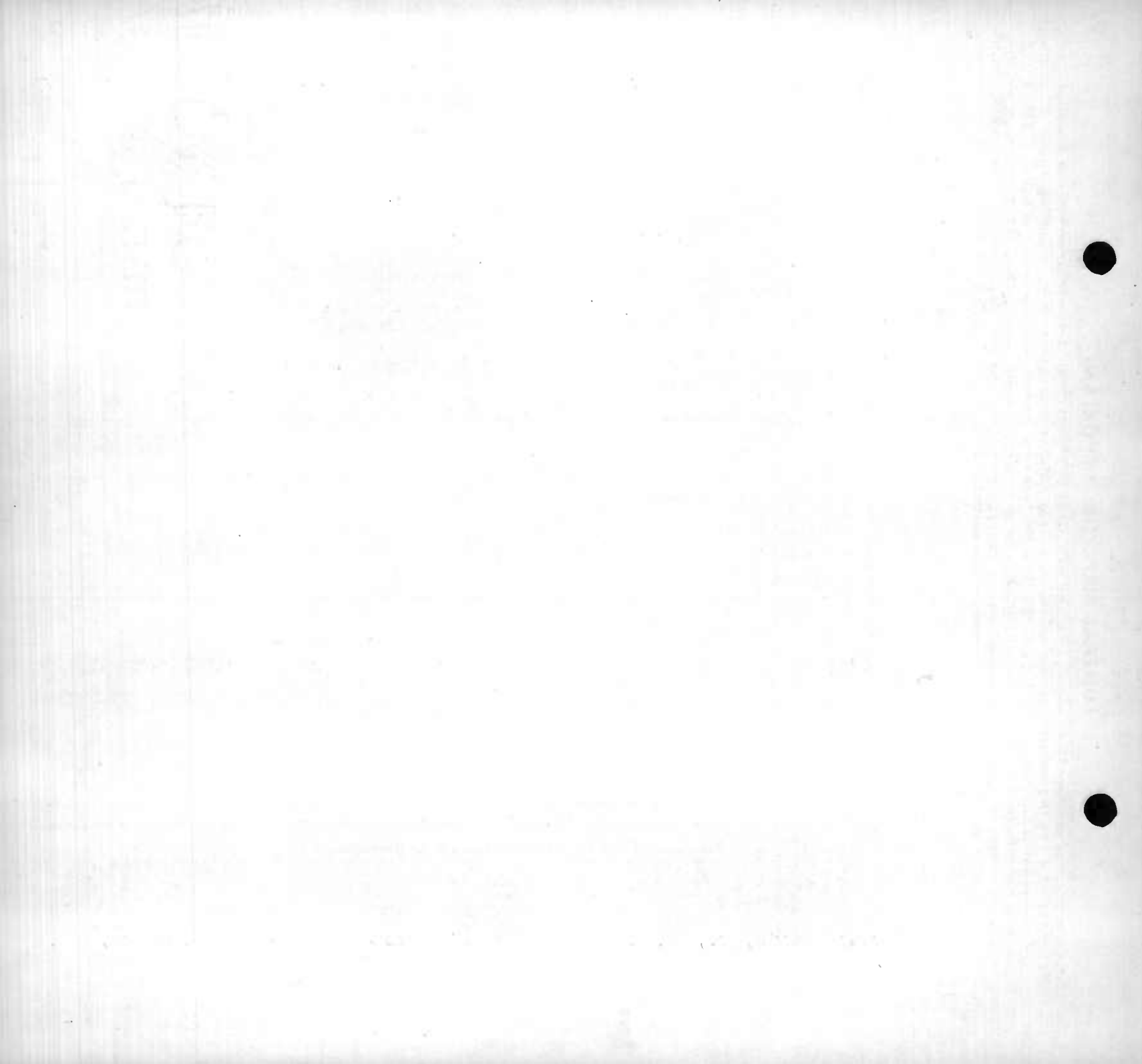
68-4912

**CERTIFICATE OF DEATH**

REG. NO.

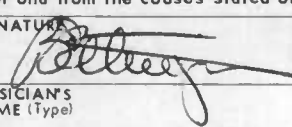
68-4912

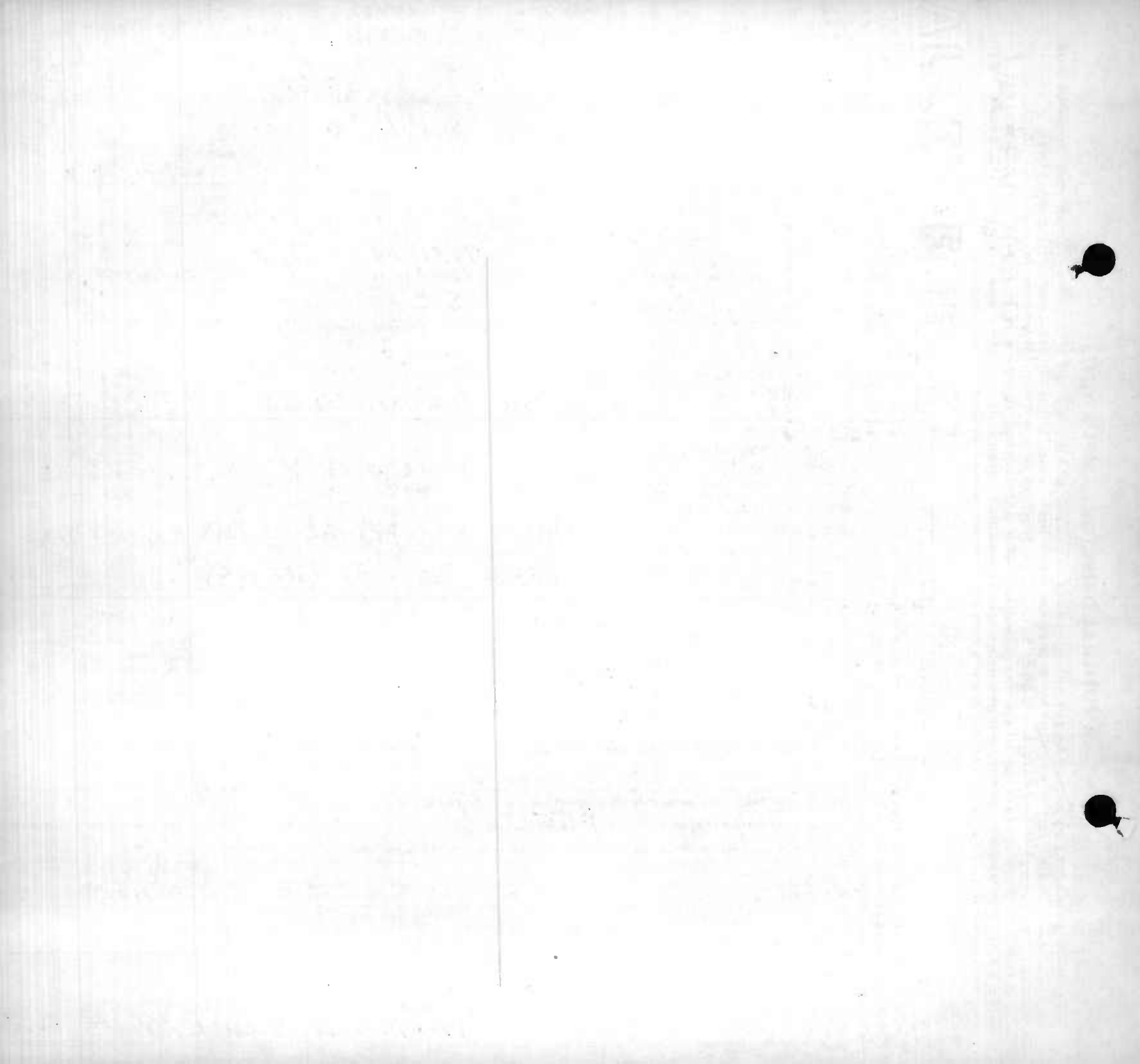
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>William W. B. Day</u>		2. DATE AND HOUR OF DEATH <u>May 9-1968</u> <u>1130 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>25-41</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>39 PROVIDENT Hosp</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Employment Agency</u>		8. DATE OF BIRTH <u>August 12-95</u> 72	
13. FATHER'S NAME <u>Wallace Day</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Lucy Bright</u>		9. AGE (In years last birthday) <u>72</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-34-5417</u>		11. BIRTHPLACE (State or foreign country) <u>Pitts Burck PA</u>	
17. INFORMANT <u>Iron Day</u>		ADDRESS <u>3605 Parkview Ave Apt B</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. <u>153.8</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Carcinoma</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of rt. colon</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
153.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>10/28/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of rt. colon</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> 19 <u>66</u> to <u>May 9</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>May 9</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Bernard Harris, Jr.</u>				23B. DATE SIGNED <u>5/10/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Bernard Harris, Jr., M.D.</u>				23D. ADDRESS <u>1200 McCulloh Street Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/13/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbuton mem PR Arbuton Back Rd 21227</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Manham &amp; Hays</u>	
				ADDRESS <u>638 N. Green St</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4913	
CERTIFICATE OF DEATH					
BIRTH NO. 5-540		68- 4913			
1. NAME OF DECEASED (Type or Print) <b>SMALL, ROBERT</b>			2. DATE AND HOUR OF DEATH <b>5/9/68 3:15 P M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>2503 Quantico Ave</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/31/19</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Cement</b>		11. BIRTHPLACE (State or foreign country) <b>S.C.</b>	
13. FATHER'S NAME <b>Paul Small</b>			14. MOTHER'S MAIDEN NAME <b>Lourd</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>250-18-6315</b>		17. INFORMANT <b>Clarean Small</b>	
				ADDRESS <b>2503 Quantico Ave</b>	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>INFARCTION OF BOWEL</b>		LESS THAN <b>24 HOURS</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(B) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>1-2 DAYS</b>
			(C) <b>FRESH - POST. OP (SEE AB)</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>540.0 II</b>					
19A. DATE OF OPERATION <b>5/9/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PERFORATING ULCER</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natively medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (i) (this hospital) attended the deceased from <b>5/1/68</b> 19 to <b>5/9/68</b> 19, that (i) (we) lost saw the deceased alive on <b>5/9/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (We) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>5/9/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/14/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem</b>	
				24D. LOCATION (City, town, or county) (State) <b>Beth. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>		25C. FUNERAL DIRECTOR <b>Wm March</b>	
				ADDRESS <b>928 E. North Ave.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO.

68-4914

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ELEANOR B. YOUNG

2. DATE AND HOUR OF DEATH

5:45 Am. 5/8/68

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

BALTIMORE CITY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

BALTIMORE

YES ☒ NO ☐

E. STREET AND NUMBER

813 ABBOTT COURT,

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

10-8-83

9. AGE (In years  
lost birthday)

84

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

SIMON BELL

14. MOTHER'S MAIDEN NAME

LAURA SMITH

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Lillian Wallace 813 Abbott Ct.

18. 440.94-1541

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerosis

6 yrs.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) Probable Carcinoma Rectum -&gt; 2 wks.

45-0.0 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

NO

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At  
Work ☐Not While  
At Work ☐

22. I certify that (I) (this hospital) attended the deceased from 5/5/68 19 to 5/8/68 19  
that (I) (we) last saw the deceased alive on 5/8/68 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

George H Reed MD

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

5/8/68

23C. PHYSICIAN'S  
NAME (Type)

GEORGE H. REED MD

23D. ADDRESS

JOHNS HOPKINS HOSP

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

5-13-68

Mt Calvary Cem

Ann Arundel Cty. Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAY 10 1968

Robert E. Taylor

WM MARLH 928 E. North Ave

*(Signature)*

2/2/2

4/8/2

Group 4 (see note)

[illegible]



68-4915 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-4915

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HATTIE MAY LEEPER

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour  
5 8 68 12:50 p.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1701 Brentwood Ave.

3. DATE PRONOUNCED DEAD Month Day Year Hour  
May 8 1968 12:50 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX  
Female

7. RACE  
Colored

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN  
Balto.

D. INSIDE CITY LIMITS?  
YES ☒ NO ☐

9. DATE OF BIRTH  
5-29-22

10. AGE (In years last birthday)  
45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

Balto. 1701 Brentwood Ave

11. BIRTHPLACE (State or foreign country)  
North Carolina

12. CITIZEN OF WHAT COUNTRY?

Calwell Stokes

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Domestic

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME  
Della Stokes

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.  
215-22-0111

18. INFORMANT ADDRESS  
Leon Stokes 1207 Druid Hill Ave.

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Hypertensive arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

20. ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

443X II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 8, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5-13-68

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 10 1968

25B. NAME OF REGISTRAR

Robert E. Fadden

25C. FUNERAL DIRECTOR

Wm C March 928 E. North Ave.

ADDRESS



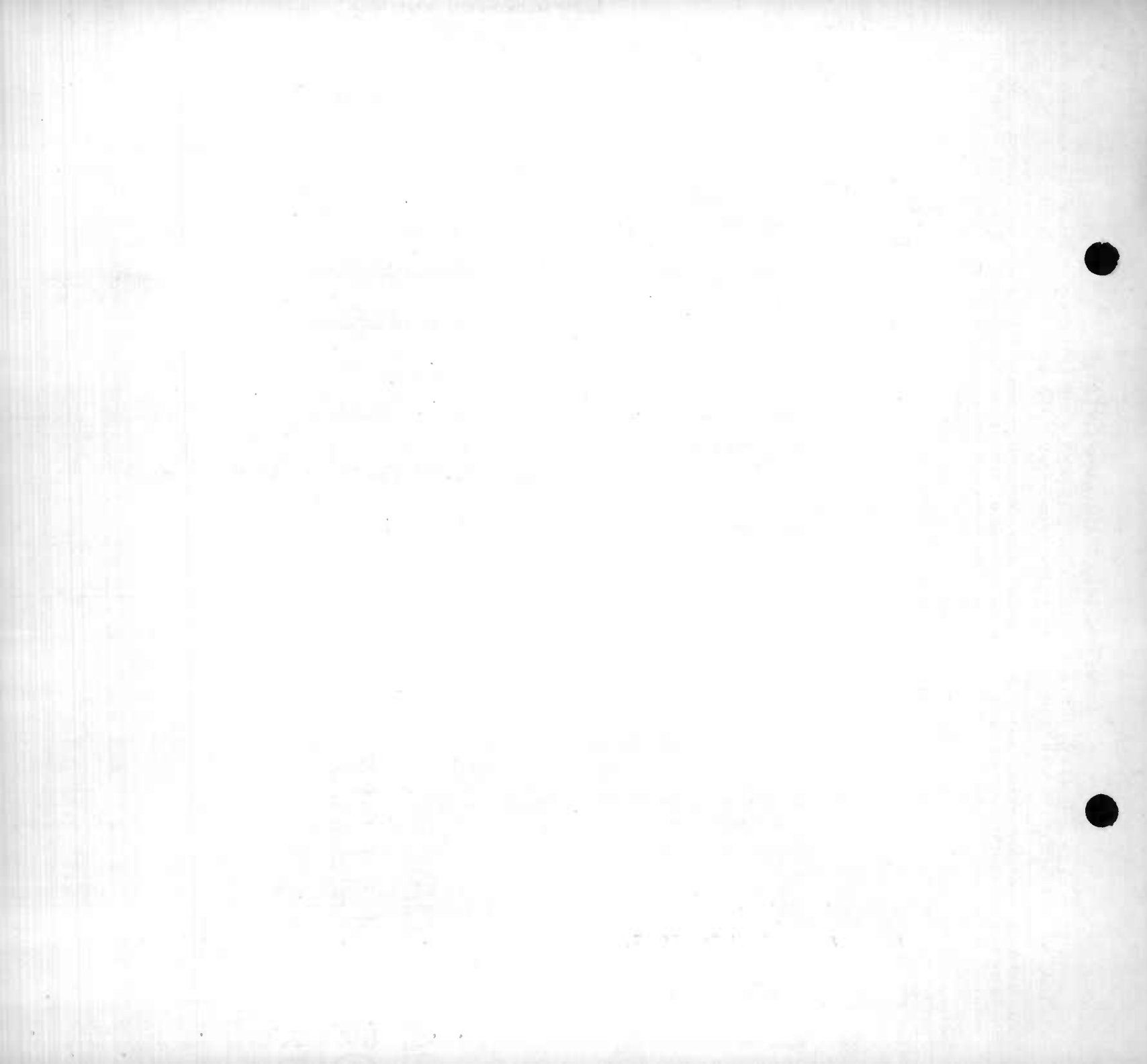
VALLEY FIDELITY

VALLEY FIDELITY

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

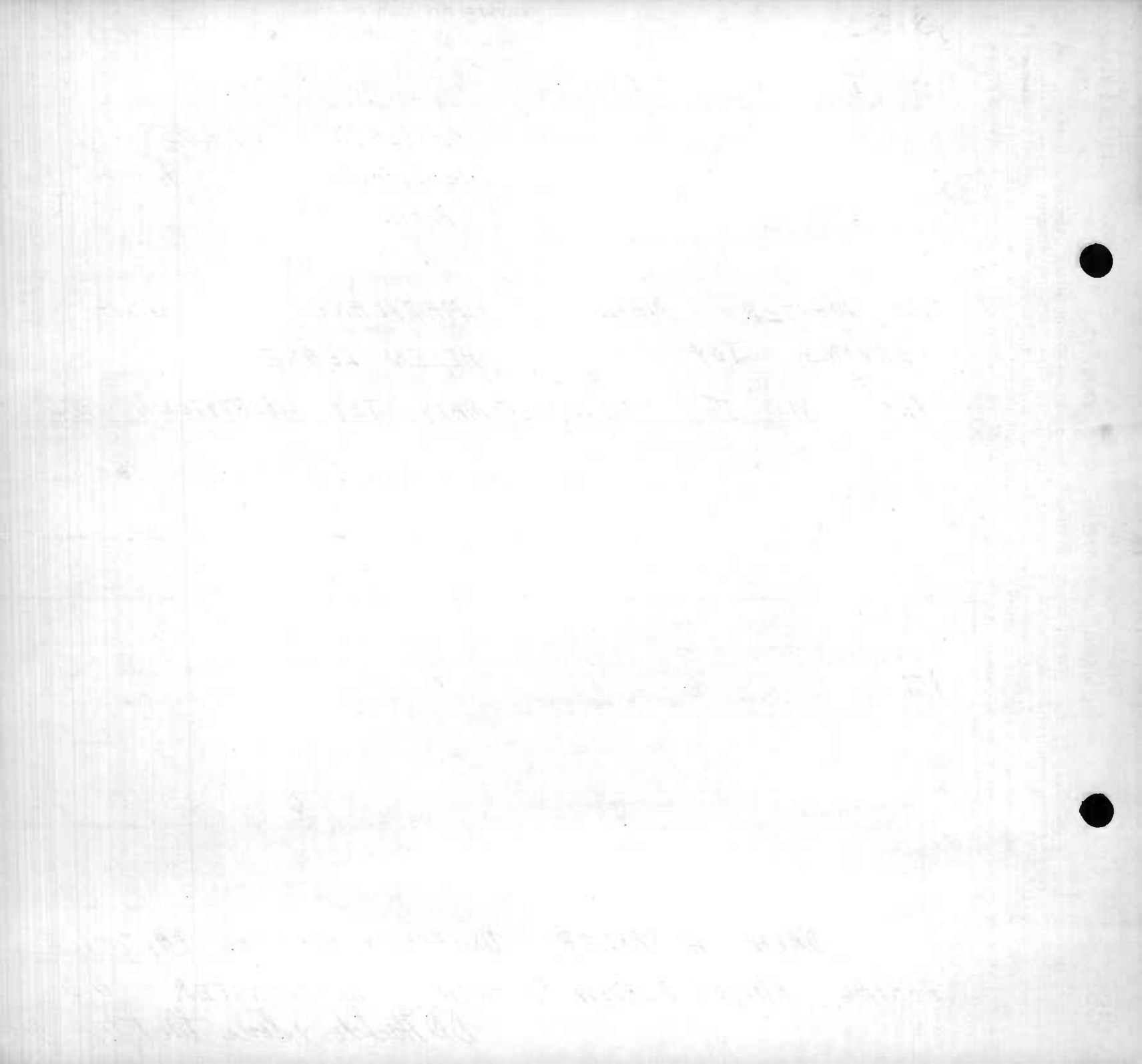
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
M-240		68-4916		88-4916	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mackall, John N.		5/6/68 5:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
Union Memorial Hosp		Maryland, Balt. City			
44		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		12 Merrymount Road			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11/5/85	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired-Eng. Road Bldg.				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John B Mackall		Louise Turner		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		215-10-5791A		Wife (Mrs. Anna)	
		18. CAUSE OF DEATH		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Cerebral Thrombosis		Same	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		ASCVD		12 hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/4/68 to 5/6/68, that (I) (we) last saw the deceased alive on 5/6/68 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
DR. BARRY J. WECKESSER		5/6/68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DR. BARRY J. WECKESSER		Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5-9-68		Druid Ridge	
		24D. LOCATION		Pikesville Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 10 1968		R. E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
5-000		68-4917		68-4917	
1. NAME OF DECEASED (Type or Print) Joy Charles IRVING			2. DATE AND HOUR OF DEATH May 7 1968 12 45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD University			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY FREDERICK		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University			C. CITY OR TOWN LIBERTYTOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER MAIN ST.					
5. SEX m	6. RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/23/20	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POST MASTER		10B. KIND OF BUSINESS OR INDUSTRY MAIL		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ERVING JOY		14. MOTHER'S MAIDEN NAME HELEN LEASE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 217-12-2365		17. INFORMANT MARY JOY LIBERTYTOWN MD	
18. 200.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 200.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gastrointestinal hemorrhage 33 days (B) Lymphosarcoma 3 years (C)		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 4 May 68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GI hemorrhage		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4 May 1968 to 7 May 1968, that (I) (we) last saw the deceased alive on 7 May 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David A Parlier MD				23B. DATE SIGNED 7 May 1968	
23C. PHYSICIAN'S NAME (Type) DAVID A PARLIER				23D. ADDRESS UNIVERSITY HOSPITAL BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/10/68		24C. NAME of CEMETERY or CREMATORY MEADOW BRANCH	
24D. LOCATION (City, town, or county) WESTMINSTER		24E. STATE MD			
25A. DATE REC'D BY HEALTH DEPT. MAY 13 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR D.D. Hartzler & Sons	
25D. ADDRESS Libertytown Md					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68-4918</b>	
<b>A-523</b> <b>68-4918</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>EARL C. ANSTINE SR.</b>		2. DATE AND HOUR OF DEATH <b>5/8/68</b> <b>1110 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 MG H. Maryland General Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>53-00</b> C. CITY OR TOWN <b>BALTO. Co</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1022 WINDSOR Rd 21208</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/9/1899</b> 9. AGE (In years last birthday) <b>69</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>auto-mechanic</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CLAYTON ANSTINE</b>		14. MOTHER'S MAIDEN NAME <b>IDA A BRUCKNER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-03-9000</b>	
17. INFORMANT <b>Md. 21208</b> ADDRESS <b>Earl C. Anstine, 2 Brightside Ave; Balto;</b>			
18. <b>410.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>CARDIAC ARREST.</b> <b>MASSIVE MYOCARDIAL INFARCT 3wk</b> <b>ASCVD.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>4/20</b> 19 <b>68</b> to <b>5/8</b> 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>5/8</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Ann K. Bruckner</b>		23B. DATE SIGNED <b>5/8/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>HOWARD WILKE</b>		23D. ADDRESS <b>MGH</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>5-11-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Reisterstown Rd; Balto, Co; Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Janky</b>	
25C. FUNERAL DIRECTOR <b>Loring Byers, 8728 Liberty Rd; Randallstown</b>		25D. ADDRESS <b>Md. 21133</b>	



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2-520		68-4919		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4919	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>ELMER HERMAN ZSCHUNKE</b>			
2. DATE AND HOUR OF DEATH <b>5-6-68 10:35 P.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b>				5. STREET AND NUMBER <b>906 WINDSOR ROAD</b>			
6. CITY OR TOWN <b>BALTIMORE 8</b>				7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-10-28</b>	
9. AGE (In years lost birthday) <b>40</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERINTENDENT LEAD CO.</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ELMER H.A. ZSCHUNKE</b>				14. MOTHER'S MAIDEN NAME <b>MARY STRATON PENNA.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>World War II</b>				16. SOCIAL SECURITY NO. <b>199-16-3433</b>		17. INFORMANT <b>MRS. AMELIA ZSCHUNKE</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MONOCYTIC LEUKEMIA</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>204.3 II</b>				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-23-68</b> to <b>5-6-68</b> , that (I) (we) last saw the deceased alive on <b>5-6-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Marlene L. Maribao M.D.</b>				23B. DATE SIGNED <b>5-6-68</b>		23C. PHYSICIAN'S NAME (Type) <b>MARLENE L. MARIBAO M.D.</b>	
23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>				23E. ADDRESS <b>UNION MEMORIAL HOSP. MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/10/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Koning Byers</b>		25D. ADDRESS <b>8728 Liberty Road Randallstown, Md.</b>	



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68-4920 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-4920

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>OLLIE C. GREEN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 10, 1968</b> <b>2:10 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 10, 1968 2:10 P.M.</b>	
6. SEX <b>male</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>negro</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Feb 2, 1926</b> <b>42</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) <b>42</b>		E. STREET AND NUMBER <b>2316 W. Lanvale Street</b> <b>16-05</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Nicholas Green</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Frances Madison</b>		ADDRESS <b>1430 Chesapeake Ave</b>	
19. <b>4124 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>422.1</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b> EXAMINER'S NAME (Type)		M.D. <b>Werner U. Spitz, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-15-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Balto Nat. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 18 1968</b>		25B. NAME OF REGISTRAR <b>Wm March</b>	
25C. FUNERAL DIRECTOR <b>Wm March</b>		ADDRESS <b>928 E. North Ave</b>	

Feb 2, 1948 42

Wardlaw

Lower

Yes WWII

Nicholas Green

Francis Johnson 1930 Chicago

Journal 2-18-48 12th Nat. Com. Balt. Md.

WM March 228 E. H. H. A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 4921				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68- 4921	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>GRACE E. LONESOME</b>				May 8, 1968			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3800 Edgeton Road</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>3800 Edgeton Road</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1-29-90</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Kenneth M. Amby</b>			14. MOTHER'S MAIDEN NAME <b>Johanna Adams</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>217-12-0847</b>		17. INFORMANT ADDRESS <b>A Clifford Lonesome 4220 Elderon Ave</b>		
18. <b>412.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ASHN; H.C.V.D.</b>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr +</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized Cathepsin -</b>				(B) DUE TO			
				(C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>420.0 II</b>				<b>N/A</b>			
19A. DATE OF OPERATION <b>N/A</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>N/A</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>N/A</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>N/A</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>N/A</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>N/A</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>N/A</b>		21F. HOW DID INJURY OCCUR? <b>N/A</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>5/17</b> 19 <b>67</b> to <b>5/7</b> 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>5/7</b> 19 <b>68</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) (did not) view the body after death.							
23A. SIGNATURE <b>U. Ray Jr</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/11/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>U. Ray Jr</b>				23D. ADDRESS <b>2225 W. North</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm C March 928 E. North Ave.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>K-431</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>68-4922</b>	
M.E. CASE NO.		68-4922		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>GERTRUDE KILDUFF</b>		2. DATE AND HOUR OF DEATH <b>4-30-68 12:25 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE UNION MEMORIAL HOSPITAL</b> <b>44</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>318 ILCHESTER AVE.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1-8-08</b>	9. AGE (In years lost birthday) <b>60</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b> <b>UNEMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>Earle E. Baldwin</b>		14. MOTHER'S LAID NAME <b>Catherine Adolphe</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT ADDRESS <b>Mr. John E. Kilduff-318 Ilchester Ave-18</b>	
18. <b>430.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Hemorrhagic shock</b> DUE TO (B) <b>Ruptured Aneurysm</b> DUE TO (C) <b>2 hours, 45 min.</b>		INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>330X II</b>					
19A. DATE OF OPERATION <b>4/29/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RUPTURED ANEURYSM</b>		20A. AUTOPSY? (Yes or No) <b>Refused</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>9:40 PM 4/29 1968</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>9:40 PM 4/29 1968</b> to <b>12:25 AM 4/30 1968</b> , that (we) last saw the deceased alive on <b>4:12:15 AM 4/30 1968</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Cesar F. Climaco</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/30/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>CESAR F. CLIMACO</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b> <b>UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>May 3, 68</b>	24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home-6500 York Rd. 21212</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4923	
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		845 A.M.	
Ruth Gail McCormick		May 6, 1968			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
Carrollton Apts.		Maryland			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		3601 Greenway			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	July 17, 1904	63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Louis Gail		Katie Bush		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-14-9245		Mr. David Fulton 102 ELMHURST RD. #10	
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Cancer of ovary		24 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
175.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1950 to May 6, 1968, that (I) (we) last saw the deceased alive on May 5, 1968, and that in (my) (our) opinion, death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. Wm. G. Helfrich				May 6, 68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Wm. G. Helfrich		5006 Roland Ave. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)		
Cremation	5-6-68	Greenmount	Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
MAY 13 1968	Robert E. Felsch	Mitchell-Wiedefeld Home		6500 York Rd. Baltimore, Md.	

General of Army

1950

May 2nd 1950

X

W. H. L. G.

May 1st

May 1st

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-4924</u>
<b>BIRTH NO.</b> <u>D-163</u> <b>1. NAME OF DECEASED</b> (Type or Print) <p style="text-align: center;"><b>August C. Dubbert</b></p>		<b>2. DATE AND HOUR OF DEATH</b> <p style="text-align: center;"><u>5/8/68</u>      <u>2:17</u> P. M.</p>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)  <p style="text-align: center;"><b>1822 Fairbank Road</b></p>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY _____ <b>C. CITY OR TOWN</b> <u>Balto.</u> <b>D. INSIDE CITY LIMITS</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <p style="text-align: center;"><b>1822 Fairbank Rd.</b></p>		
<b>5. SEX</b> <u>male</u>	<b>6. RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <p style="text-align: center;"><u>10/31/1893</u></p>	<b>9. AGE</b> (In years lost birthday) <u>74</u> If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <p style="text-align: center;"><b>Nursery &amp; Flower Shop</b></p>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <p style="text-align: center;"><b>Germany</b></p>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <p style="text-align: center;"><b>USA</b></p>
<b>13. FATHER'S NAME</b> <p style="text-align: center;"><b>Frederick Dubbert</b></p>		<b>14. MOTHER'S MAIDEN NAME</b> <p style="text-align: center;"><b>Charlotte ----</b></p>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (If yes, give war or dates of service) <p style="text-align: center;"><u>no</u></p>		<b>16. SOCIAL SECURITY NO.</b> <p style="text-align: center;"><u>212-10-3044</u></p>		<b>17. INFORMANT</b> <p style="text-align: center;"><b>Anna W. Dubbert</b></p>
<b>18. <u>410.91</u></b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <p style="text-align: center;"><u>420.11</u>      <u>II</u></p>		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <p style="text-align: center;"><u>Caduce Arrest -</u></p> (B) DUE TO, OR AS A CONSEQUENCE OF: <p style="text-align: center;"><u>Crown Thrombosis</u></p> (C) <u>Arteriosclerosis. Cordis -</u> <p style="text-align: center;"><u>Vascular Disease</u></p>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <p style="text-align: center;"><u>Sudden</u></p> <p style="text-align: center;"><u>2 hours</u></p> <p style="text-align: center;"><u>?</u></p>
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <p style="text-align: center;"><u>No</u></p>		<b>20A. AUTOPSY?</b> (Yes or No) <p style="text-align: center;"><u>No</u></p>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <p style="text-align: center;"><u>At Work</u></p>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <p style="text-align: center;"><u>At Work</u></p>
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <p style="text-align: center;"><u>5/8</u></p>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <p style="text-align: center;"><u>5/8</u></p>
<b>22. I certify that (I) (this hospital) attended the deceased from <u>5/8</u> 19<u>68</u> to <u>5/8</u> 19<u>68</u>, that (I) (we) lost saw the deceased alive on <u>5/8</u> 19<u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <p style="text-align: center;"><u>Joseph S. Blum</u></p>		<b>23B. DATE SIGNED</b> <p style="text-align: center;"><u>5/8/68</u></p>		<b>23C. PHYSICIAN'S NAME</b> (Type) <p style="text-align: center;"><b>Dr. Joseph Blum</b></p>
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <p style="text-align: center;"><u>burial</u></p>		<b>24B. DATE</b> <p style="text-align: center;"><u>5/10/68</u></p>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <p style="text-align: center;"><b>Loudon Park</b></p>
<b>24D. LOCATION</b> (City, town, or county) (State) <p style="text-align: center;"><b>Balto., Md.</b></p>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <p style="text-align: center;"><b>MAY 13 1968</b></p>		
<b>25B. NAME OF REGISTRAR</b> <p style="text-align: center;"><u>Robert E. Taylor</u></p>		<b>25C. FUNERAL DIRECTOR</b> <p style="text-align: center;"><b>Mitchell-Wiedefeld Home</b></p>		
<b>25D. ADDRESS</b> <p style="text-align: center;"><b>6500 York Rd.</b></p>		<b>25E. ADDRESS</b> <p style="text-align: center;"><b>Balto., Md. 21212</b></p>		

James Smith

James Smith

James Smith

James Smith

James Smith

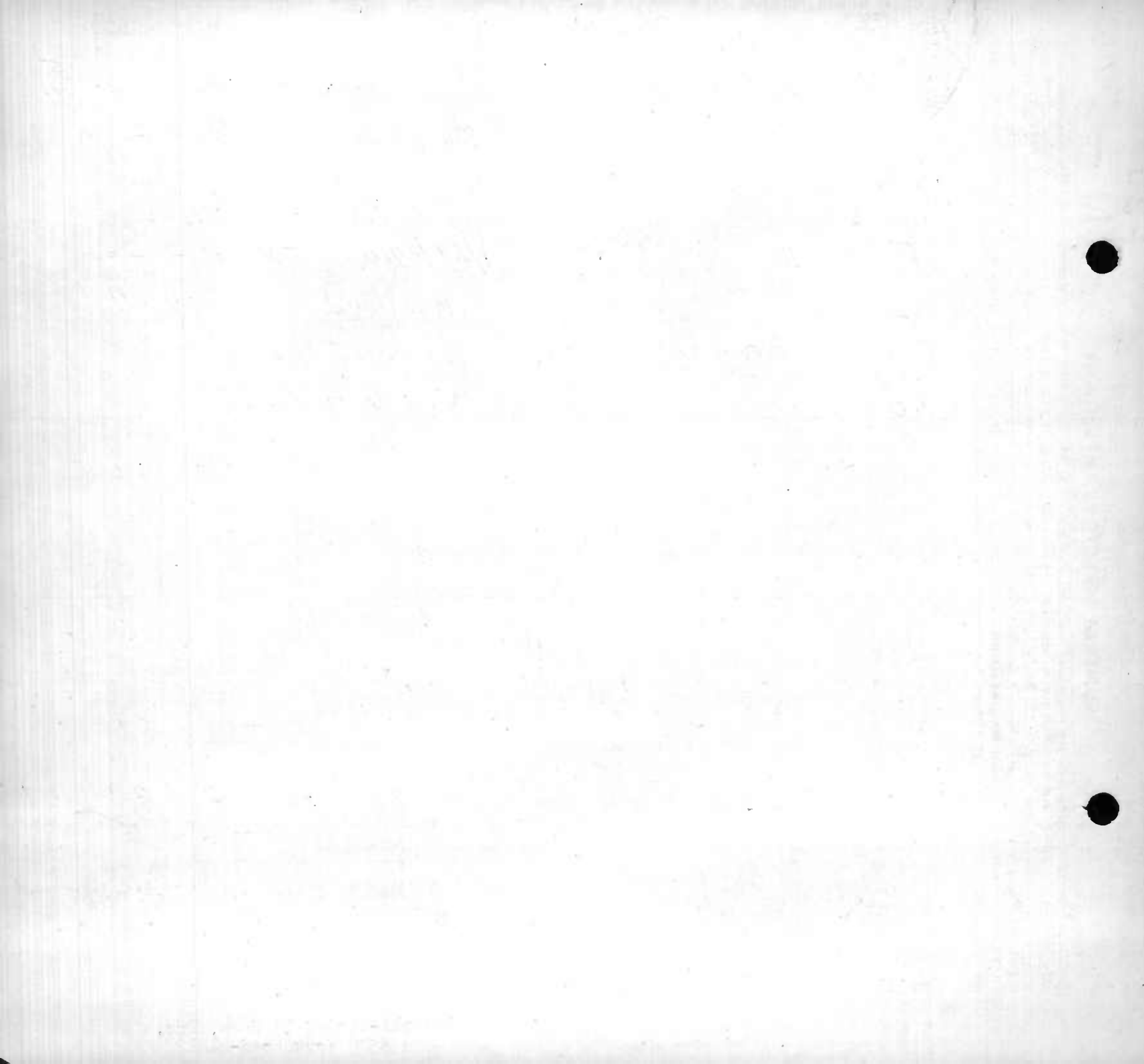
James Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-4925</u>	
L-532		68-4925		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Lentz, Margaret M</u>		2. DATE AND HOUR OF DEATH <u>May 2, 1968</u> <u>6<sup>15</sup></u> <u>A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>21212</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles General Hospital</u> <u>49</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>27-38</u>	
		E. STREET AND NUMBER <u>1311 Meridene Drive</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/24/1910</u>	9. AGE (In years last birthday) <u>58</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Francis Reagan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kelly</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-03-6456</u>		17. INFORMANT <u>N. C. R. H. Chart</u>	
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinomatous pneumonia</u> (B) <u>Brucogenic Ca</u> DUE TO, OR AS A CONSEQUENCE OF: (C) —			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION					
162.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-20</u> <u>1968</u> to <u>5-2</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>5-2</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Arthur P. Jones</u>		23B. DATE SIGNED <u>5-2-68</u>		23C. PHYSICIAN'S NAME (Type) <u>Joe Blum, MD</u>	
23D. ADDRESS		23E. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/6/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 13 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home, Inc.</u>	
25D. ADDRESS <u>6500 York Road-21212</u>					

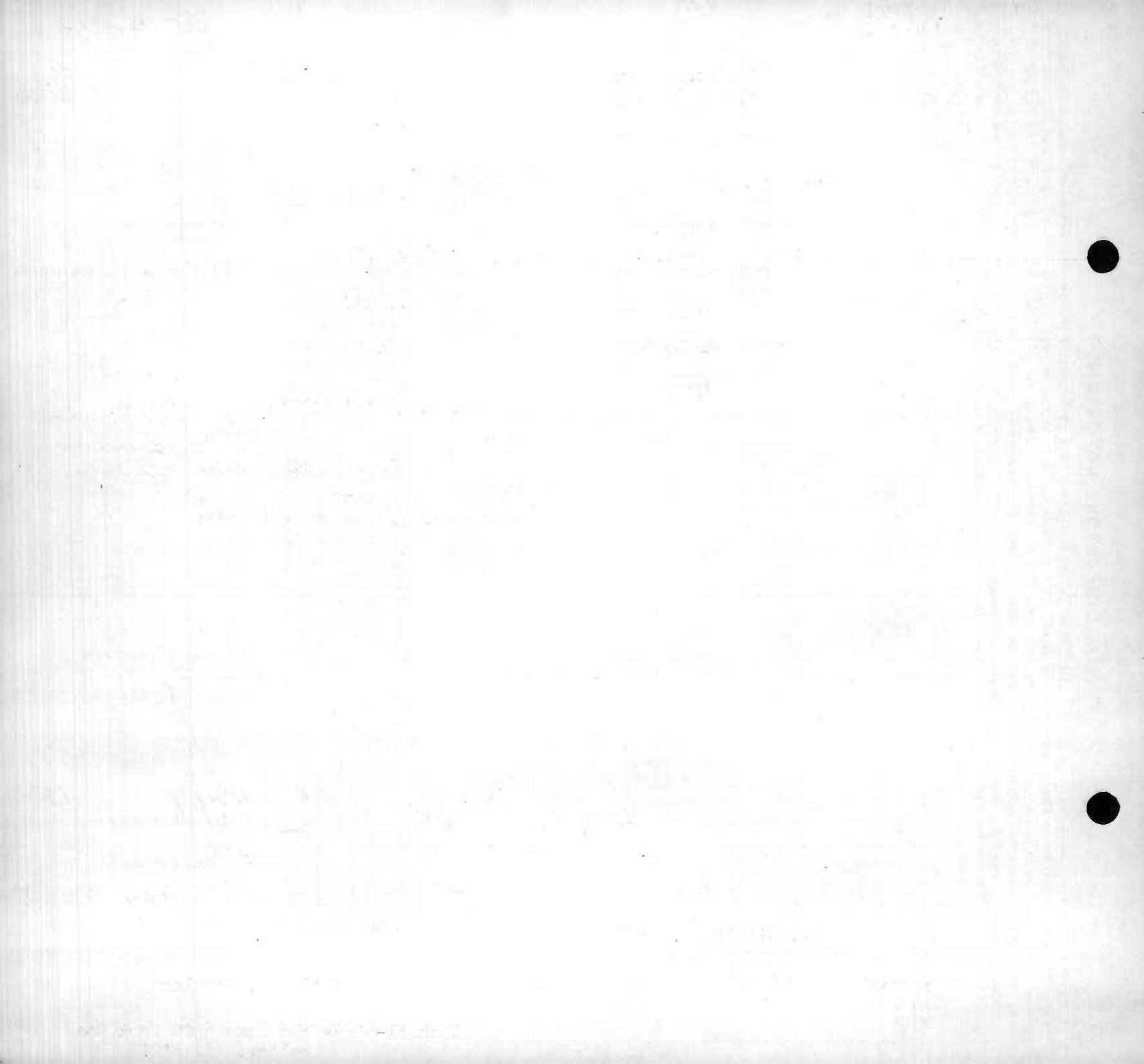




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

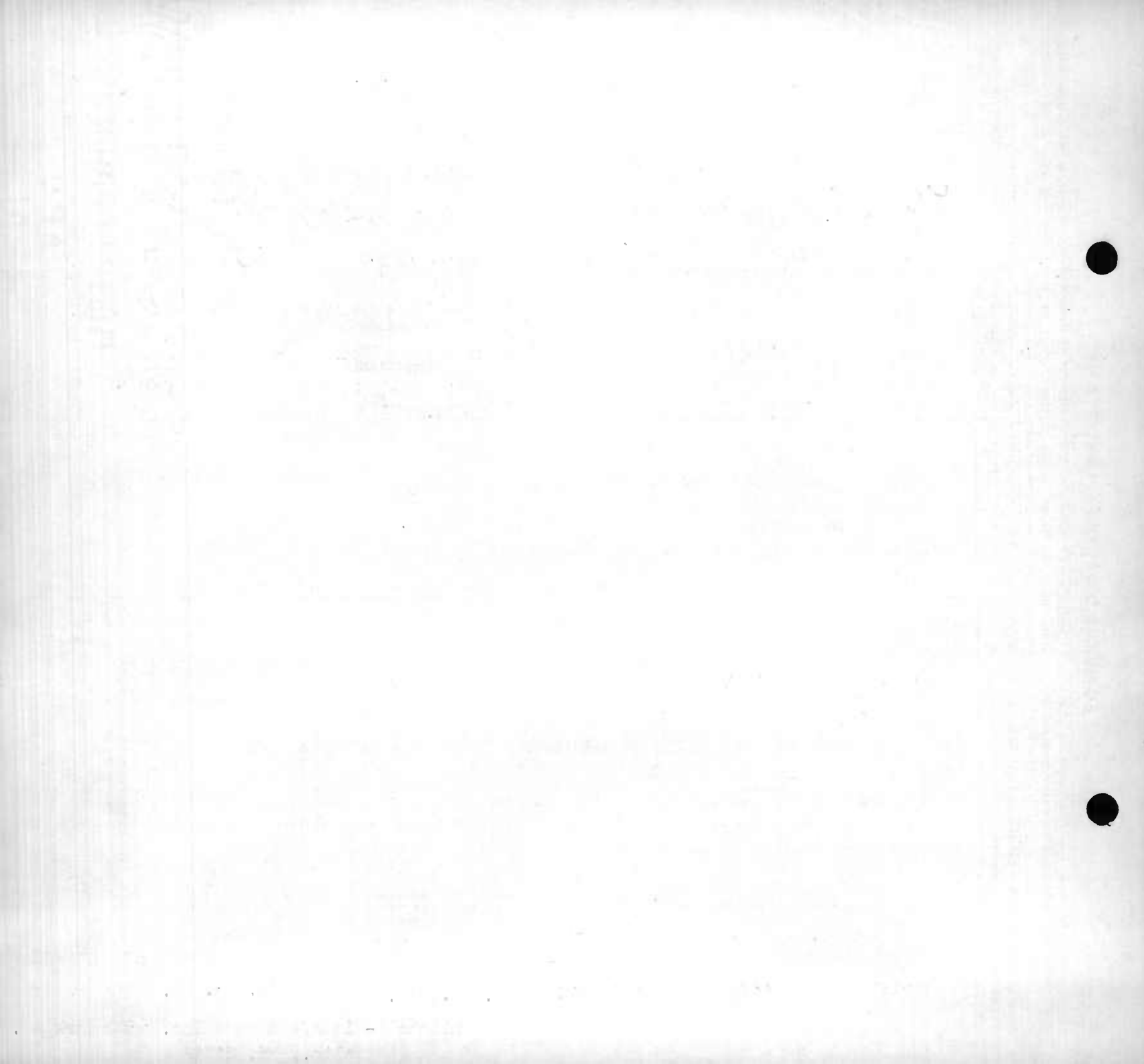
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4926</b>						
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Alfred B. Morton</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>May 1, 1968</b>								
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>218 Ridgewood Road</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>Maryland</b> <b>B. COUNTY</b>  <b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>4204 Wickford Road</b>								
<b>5. SEX</b> <b>male</b>	<b>6. RACE</b> <b>white</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>October 8, 1887</b>							
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>lawyer</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Balto., Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>						
<b>13. FATHER'S NAME</b> <b>Franklin J. Morton</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Fannie Nason</b>							
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Mrs. L. Elliot Williams</b> <b>Bowie, Md.</b>						
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>  <b>412.4 I</b>  <b>Coronary Heart Failure</b>                      (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>  <b>422.1 II</b>  <b>Other Significant Conditions Contributing to the Death but not related to the terminal disease or condition given in Part 1 (A).</b>  <b>19A. DATE OF OPERATION</b>  <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  <b>20A. AUTOPSY? (Yes or No)</b> <input checked="" type="checkbox"/> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> </td> <td style="width: 50%; vertical-align: top;"> <b>CAUSE OF DEATH</b>  <b>Coronary Heart Failure</b>  <b>(A) IMMEDIATE CAUSE</b>  <b>Due to, or as a consequence of:</b>  <b>Myocardial Infarction</b>  <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>Advanced Arterio-Sclerosis</b>  <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> </td> </tr> </table>					<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>412.4 I</b> <b>Coronary Heart Failure</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> <b>422.1 II</b> <b>Other Significant Conditions Contributing to the Death but not related to the terminal disease or condition given in Part 1 (A).</b> <b>19A. DATE OF OPERATION</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY? (Yes or No)</b> <input checked="" type="checkbox"/> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	<b>CAUSE OF DEATH</b> <b>Coronary Heart Failure</b> <b>(A) IMMEDIATE CAUSE</b> <b>Due to, or as a consequence of:</b> <b>Myocardial Infarction</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Advanced Arterio-Sclerosis</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>				
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>412.4 I</b> <b>Coronary Heart Failure</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> <b>422.1 II</b> <b>Other Significant Conditions Contributing to the Death but not related to the terminal disease or condition given in Part 1 (A).</b> <b>19A. DATE OF OPERATION</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY? (Yes or No)</b> <input checked="" type="checkbox"/> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	<b>CAUSE OF DEATH</b> <b>Coronary Heart Failure</b> <b>(A) IMMEDIATE CAUSE</b> <b>Due to, or as a consequence of:</b> <b>Myocardial Infarction</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Advanced Arterio-Sclerosis</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>									
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; vertical-align: top;"> <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/> </td> <td style="width: 33%; vertical-align: top;"> <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                             </td> <td style="width: 33%; vertical-align: top;"> <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                             </td> </tr> <tr> <td style="vertical-align: top;"> <b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)                             </td> <td style="vertical-align: top;"> <b>21E. INJURY OCCURRED</b>  <b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input type="checkbox"/> </td> <td style="vertical-align: top;"> <b>21F. HOW DID INJURY OCCUR?</b> </td> </tr> </table>					<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>	<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)	<b>21E. INJURY OCCURRED</b> <b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input type="checkbox"/>	<b>21F. HOW DID INJURY OCCUR?</b>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>	<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)								
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)	<b>21E. INJURY OCCURRED</b> <b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input type="checkbox"/>	<b>21F. HOW DID INJURY OCCUR?</b>								
<b>22. I certify that (I) (this hospital) attended the deceased from Jan 1968 to May 1 1968, that (I) (we) last saw the deceased alive on May 1 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>										
<b>23A. SIGNATURE</b>  <b>23C. PHYSICIAN'S NAME (Type)</b> <b>Dr. William H. Woody</b>			<b>23B. DATE SIGNED</b> <b>May 3-68</b>							
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>cremation</b>			<b>24B. DATE</b> <b>5/4/68</b>							
<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Greenmount</b>			<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>							
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 13 1968</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Fisher</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Mitchell-Wiedefeld Home</b> <b>6500 York Road</b> <b>Balto., Md. 21212</b>						



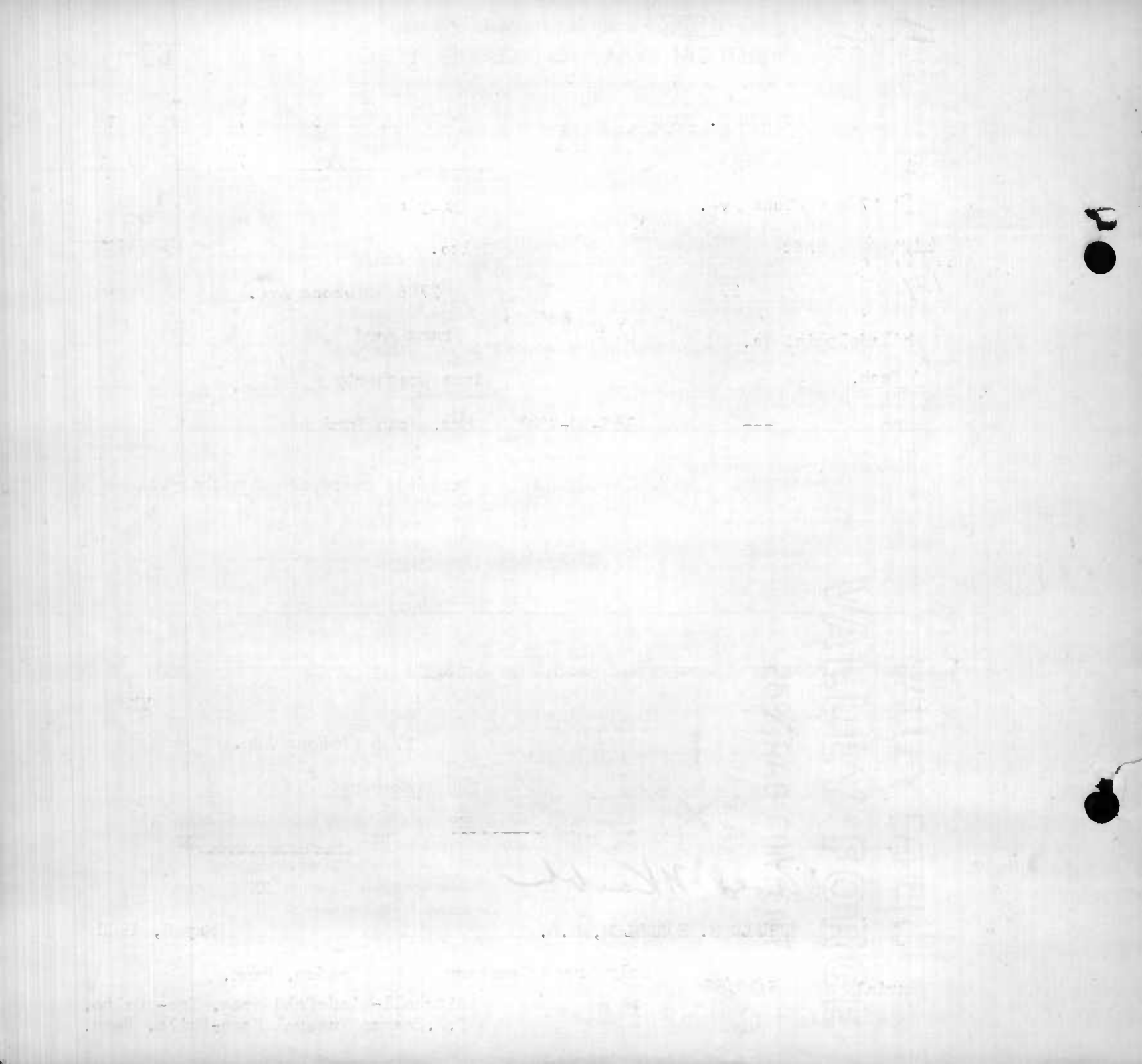
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4927
5-365		68-4927		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Elizabeth Sturm</i>		
2. DATE AND HOUR OF DEATH <i>5-8-68</i>		1 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Little Sisters of The Poor</i> <i>1200 Valley St.</i> <i>Balt. Md. 21202</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>F</i> 6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-9-1880</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>87</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George Stallo</i>		14. MOTHER'S MAIDEN NAME <i>Wilhemina Debring</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-30-9971B</i>		17. INFORMANT <i>MRS. DELORES GORE 715 MURDOCK RD #21212</i> <i>Little Sisters of The Poor</i>
18. <i>174X I</i>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Terminal Ca of the Breast</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
170X II		(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>1967</i> to <i>May 8</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>May 8</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Stanley Ankudras</i>		23B. DATE SIGNED <i>5-9-68</i>		23C. PHYSICIAN'S NAME (Type) <i>STANLEY ANKUDRAS</i>
23D. ADDRESS <i>1101 Maiden Choice Ln, Balto 21202</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>5/11/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Mem. Pk. Cem.</i>
24D. LOCATION (City, town, or county) (State) <i>Balto. Co. Md.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 13 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home Inc. 6500 York Rd. Balto., Md. 21212</i>



BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4928			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
JOSEPH M. FORD				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month Day Year Hour			
00 2706 Gibbons Ave.				May 7 1968 ? M.			
6. SEX Male				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
7. RACE white				A. STATE Maryland			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				B. COUNTY			
9. DATE OF BIRTH 12/8/1938				C. CITY OR TOWN Balto.			
10. AGE (In years last birthday) 29				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.				E. STREET AND NUMBER 2706 Gibbons Ave.			
12. CITIZEN OF U.S.A.				13. FATHER'S NAME Frank Ford			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tech.				15. MOTHER'S MAIDEN NAME Anna Dougherty			
14B. KIND OF BUSINESS OR INDUSTRY				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no ---			
17. SOCIAL SECURITY NO. 165-30-4341				18. INFORMANT Mrs. Joan Ford			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E980.13				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE Probable overdose of methapyrilene DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). E936.0 II							
20A. DATE OF OPERATION				21. AUTOPSY? (Yes or No) YES			
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED							
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 22D. TIME OF INJURY (APPROX.) ?				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2706 Gibbons Ave. 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 22F. HOW DID INJURY OCCUR? Unknown			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) RONALD N. KORNBLUM, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED May 8, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5/10/68		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Yeadon, Penn.	
25A. DATE RECEIVED BY HEALTH DEPT. MAY 13 1968				25B. NAME OF REGISTRAR R. E. Faldut			
				25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc- Balto. T.F. Reagan Funeral Home-Phila, Penn.			





1

R-162 68-4929 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-4929

BIRTH NO.		1. NAME OF DECEASED (Type or Print) VERNON ROBERSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> May 6, 1968 Hour 11:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1123 Ramble wood Road - Apt. B		3. DATE PRONOUNCED DEAD Month Day Year May 7, 1968 Hour 7:00 A.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Oct 11, 1908		10. AGE (In years lost birthday) 59		E. STREET AND NUMBER 1123 Ramblewood Road	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF U.S.A.		13. FATHER'S NAME Walter C. Roberson	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parts Salesman		14B. KIND OF BUSINESS OR INDUSTRY auto		15. MOTHER'S MAIDEN NAME W Estella Deshon	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 180 03 8543		18. INFORMANT Estelle Roberson 1123 Ramblewood Rd.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. 422.1 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/7/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/9/68		24C. NAME OF CEMETERY or CREMATORY Landon Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 13 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Mitchell Weidensel		ADDRESS 600 York St			

Received 27/9/88  
Kendall's

D-000

68-4930

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-4930

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH DAYA</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 5 8 68 2:55 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. Agnes Hospital D.O.A.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 8 1968 2:55 p.m.</b>			
6. SEX <b>Male</b>				7. RACE <b>White</b>			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN <b>Baltimore, Brooklyn Pk.</b>			
9. DATE OF BIRTH <b>Nov. 28, 1901</b>				10. AGE (In years last birthday) <b>66</b>			
11. BIRTHPLACE (State or foreign country) <b>Mt. Carmel, Pa.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>				14B. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				17. SOCIAL SECURITY NO. <b>181-09-0322A</b>			
18. INFORMANT <b>Mrs. Frances Ladika</b>				ADDRESS <b>-321 Old Riverside Rd.</b>			
19. CAUSE OF DEATH <b>492X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary emphysema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>527.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				21. AUTOPSY? (Yes or No) <b>No</b>			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>XXX</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5-9-68</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-11-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Hgwy., A.A.Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jankov</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George J. Gonce-4001 Ritchie Hgwy., Baltimore</b>			

*Paul H. Smith*

Paul H. Smith, Esq.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4931	
<div style="display: flex; justify-content: space-between;"> <span>M-220</span> <span>68-4931</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MYSZKOWSKI, AGNES BARBARA		MAY 9, 1968 2:35 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  ST AGNES HOSPITAL			A. STATE MARYLAND		
			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 207 E. CHARLES STREET		
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03/24/01	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 67	
Store Manager-Owner		Grocery		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ANDREW FABULA			14. MOTHER'S MAIDEN NAME BARBARA CHETTA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		218-44-1930		ST AGNES RECORDS-WILKENS & CATON AVES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  CVA		2 days
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(B) DUE TO, OR AS A CONSEQUENCE OF:  Congestive Heart Failure C/Mr		
			(C) _____		
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from MAY 3, 19 68 to MAY 9, 19 68, that (X) (we) last saw the deceased alive on MAY 9, 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  Raymond Bahr				23B. DATE SIGNED 5/9/68	
23C. PHYSICIAN'S NAME (Type) RAYMOND BAHR				23D. ADDRESS ST AGNES HOSPITAL-CATON & WILKENS AVE BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5-13-1968		Holy Cross Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 13 1968		Robert E. Feltz		George J. Gonce-4001 Ritchie Hwy., Baltimore	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-4932</u>
BIRTH NO. <u>C-142</u>		68-4932 <b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>CEBULSKI MR JOHN</b>		2. DATE AND HOUR OF DEATH <b>5-10-1968 5-50 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME AND HOSPITAL 35</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER <b>1726 LANCASTER ST.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-22-03</b>	9. AGE (In years lost birthday) <b>64</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAREHOUSEMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CONTINENTAL CAN CO</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>MICHAEL CEBULSKY</b>		
14. MOTHER'S MAIDEN NAME <b>MARY ROZALSKA</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>215-03-7450</b>		17. INFORMANT <b>ANNA CEBULSKI</b> ADDRESS <b>1726 LANCASTER ST. BALTO. MD. 21231</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <b>PERITONITIS; PNEUMONIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>CA PANCREAS</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>15-7X II</b>				
19A. DATE OF OPERATION <b>4-30-68</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca head of pancreas</b>	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>4-19-1968</b> to <b>5-10-1968</b> , that (I) (we) last saw the deceased alive on <b>5-10-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Dr. R. Atkins</b>		23B. DATE SIGNED <b>5-10-68</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>Dr. R. Atkins</b>		23D. ADDRESS <b>CH &amp; A</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5-14-68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>	25C. FUNERAL DIRECTOR ADDRESS <b>W. Fialkowski 2007 Eastern</b>		



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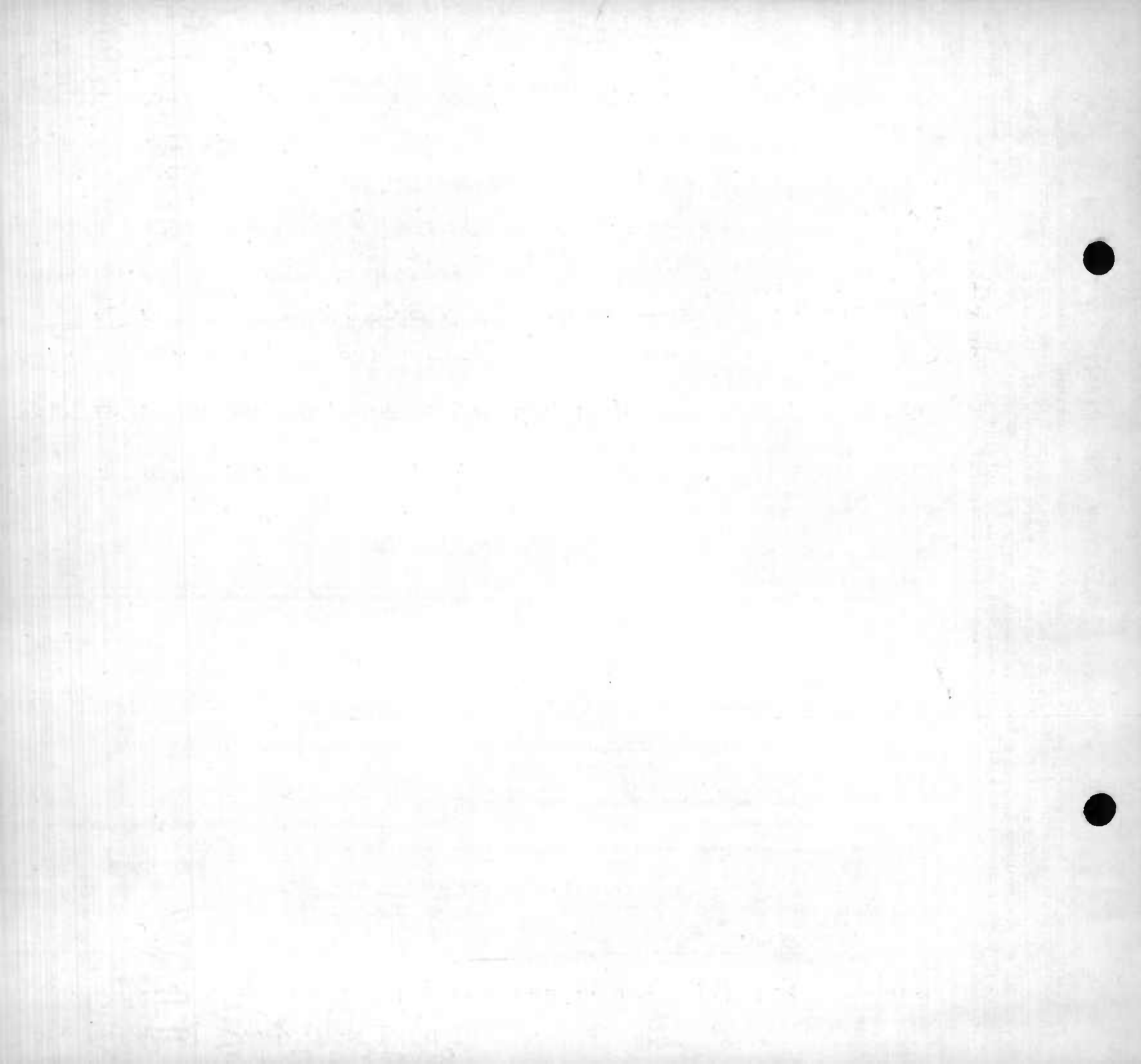
CH 5



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4933	
P-436		68-4933		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Milton Pilchard.		5-6-68 10:30 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
University Hospital.			Md. WORCESTER Co 73-00		
38			C. CITY OR TOWN Girdle tree		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER Box 72		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10/06	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10B. KIND OF BUSINESS OR INDUSTRY RETAIL STORE		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Clarence Pilchard			
14. MOTHER'S MAIDEN NAME Lavenia Pilchard (also)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -			
16. SOCIAL SECURITY NO. 28-34-8834		17. INFORMANT Mrs ETHELYNE PILCHARD, GIRDLETREE, MD.			
18. 433.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) INtra cerebral thrombosis -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 332 X II					
19A. DATE OF OPERATION 4/30/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intra cerebral Hematoma		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/26 1968 to 5-6 1968, that (I) (we) last saw the deceased alive on 5-6 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE O. Polanco, M.D.		23B. DATE SIGNED 5/6/68			
23C. PHYSICIAN'S NAME (Type) Octavio Polanco		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-9-1968		24C. NAME OF CEMETERY or CREMATORY SPRING HILL CEMETERY	
24D. LOCATION (City, town, or county) (State) GIRDLETREE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. MAY 13 1968		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Robert H. Watson	
25D. ADDRESS Baltimore, MD.					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68 4934</span>
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">MARY F VONPOSTEL</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">MAY 10, 1968</span> <span style="float: right;">2:15 A.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">THE UNION MEMORIAL HOSPITAL</span> ADDRESS OR LOCATION <span style="font-size: 1.2em;">3322 CALVERT ST BALTIMORE, MARYLAND</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">3711 ROLAND AVENUE</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">FEMALE</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">CAUCASIAN</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">05 11-06-08</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">62</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Payroll Dept</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">INSURANCE Co</span>		
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">SOUTH CAROLINA</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">John W. RYAN</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">MINNIE NELSON</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">202-01-8552</span>		
<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mr. Richard L. Vonpostel (husband)</span>		<b>ADDRESS</b> <span style="font-size: 1.2em;">3711 Roland Ave</span>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.2em;">3322 X II</span>		<b>CAUSE OF DEATH</b> <span style="font-size: 1.2em;">Cardiac tamponade</span> <b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">Cerebrovascular Accident</span> DUE TO, OR AS A CONSEQUENCE OF:  <b>(B) Thrombosis of Middle Cerebral Artery</b> DUE TO, OR AS A CONSEQUENCE OF:  <b>(C) Arteriosclerosis</b>		
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">None</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">None</span>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">yes</span>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">INJURY OCCUR?</span>		
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> White At Work <input type="checkbox"/> Nat. While At Work <input type="checkbox"/>		
<b>21F. HOW DID INJURY OCCUR?</b>		<b>22. I certify that</b> (this hospital) attended the deceased from <span style="font-size: 1.2em;">MAY 7, 1968</span> to <span style="font-size: 1.2em;">MAY 10, 1968</span> , that (we) last saw the deceased alive on <span style="font-size: 1.2em;">MAY 10, 1968</span> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.		
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">William H. Spencer-Strong MD.</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">May 10, 1968</span>		<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">WILLIAM H. SPENCER-STRONG MD.</span>
<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">5/13/68</span>		
<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">New Cathedral Cemetery</span>		<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAY 13 1968</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Austin E. Donovan</span>		
<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Austin E. Donovan</span>		<b>ADDRESS</b> <span style="font-size: 1.2em;">-3818 Roland Ave.</span>		

THE ...

William H. Jones - May 10

MAY 10

MAY 10

Now

you

Arteriosclerosis

Thrombosis of Arteries

Cerebrovascular Disease

No

John W. Ryan

MINIE WELTON

Insurance Co South Carolina

Female Caucasian

11-02-02

At Home, Maryland

11-02-02

At Home, Maryland

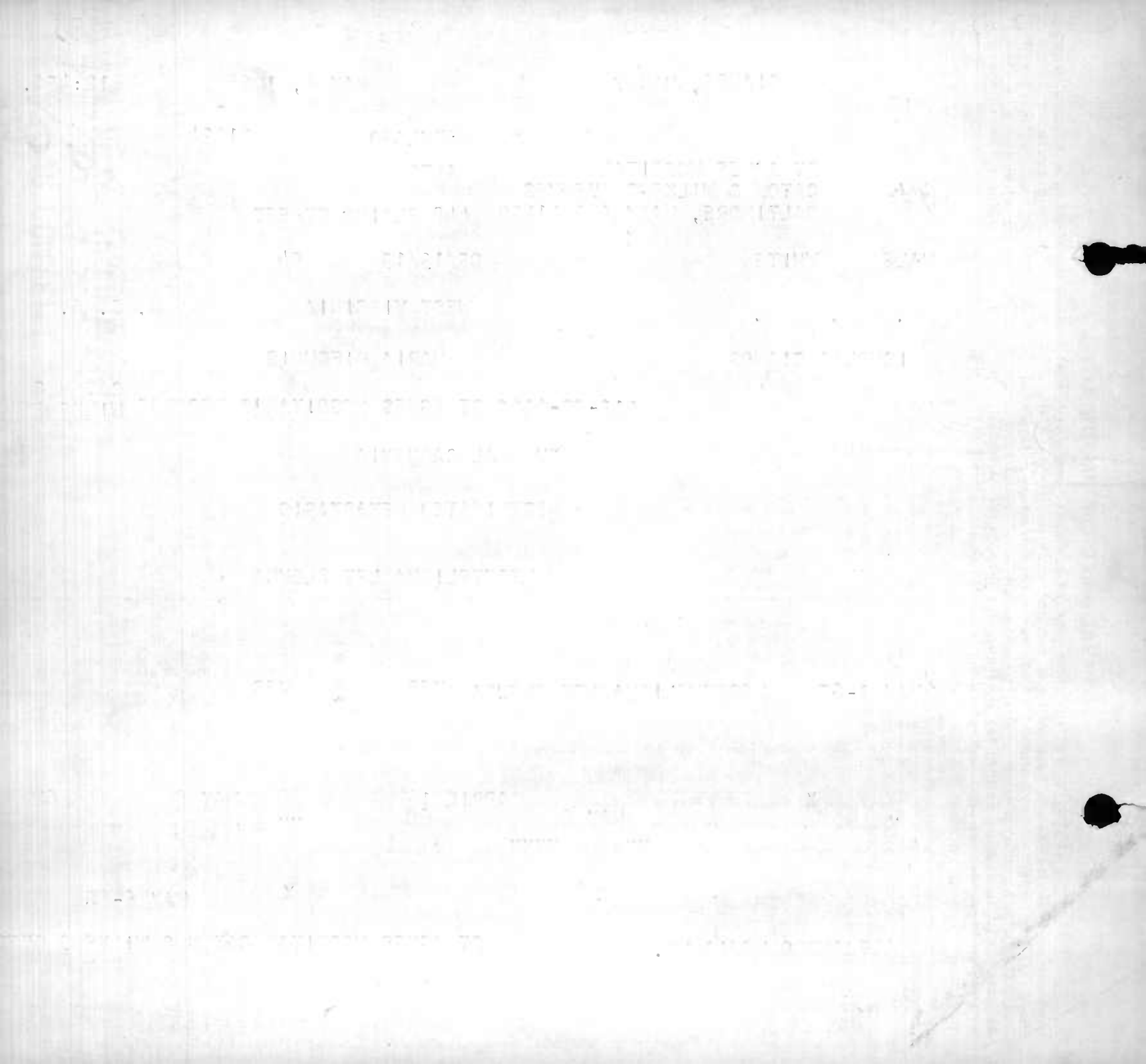
11-02-02

11-02-02

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4935	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>CIANOS, HARRY</b>	
2. DATE AND HOUR OF DEATH <b>MAY 6, 1968</b>				12:45A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21224</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVENUES BALTIMORE, MARYLAND 21229</b>				C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>448 ELRINO STREET</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>05/13/13</b>	9. AGE (In years lost birthday) <b>54</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ind. Rel. Dept.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>NICHOLAS CIANOS</b>	
14. MOTHER'S MAIDEN NAME <b>MARIA DIFOUNIS</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>213-07-4123</b>				17. INFORMANT <b>CATON &amp; WILKENS</b>	
18. <b>163,01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>TUMORAL CAQUEXIA</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>DISEMINATED METASTASIS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>MESOTELIOMA LFT PLEURA</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>163X II</b>					
19A. DATE OF OPERATION <b>MAY 1-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MESOTHELIOMA LFT PLEURA</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>YES</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>APRIL 16</b> 19 <b>68</b> to <b>MAY 6</b> 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MAY 6</b> 19 <b>68</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <i>Alejandro Mejia</i> DEGREE				23B. DATE SIGNED <b>MAY 6-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALEJANDRO MEJIA MD.</b>				23D. ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVES</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-9-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery Baltimore, Md.</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>			
25B. NAME OF REGISTRAR <i>Robert E. Faldy</i>		25C. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b>			
25D. ADDRESS <b>3021 Eastern Ave., Baltimore, Md.</b>					



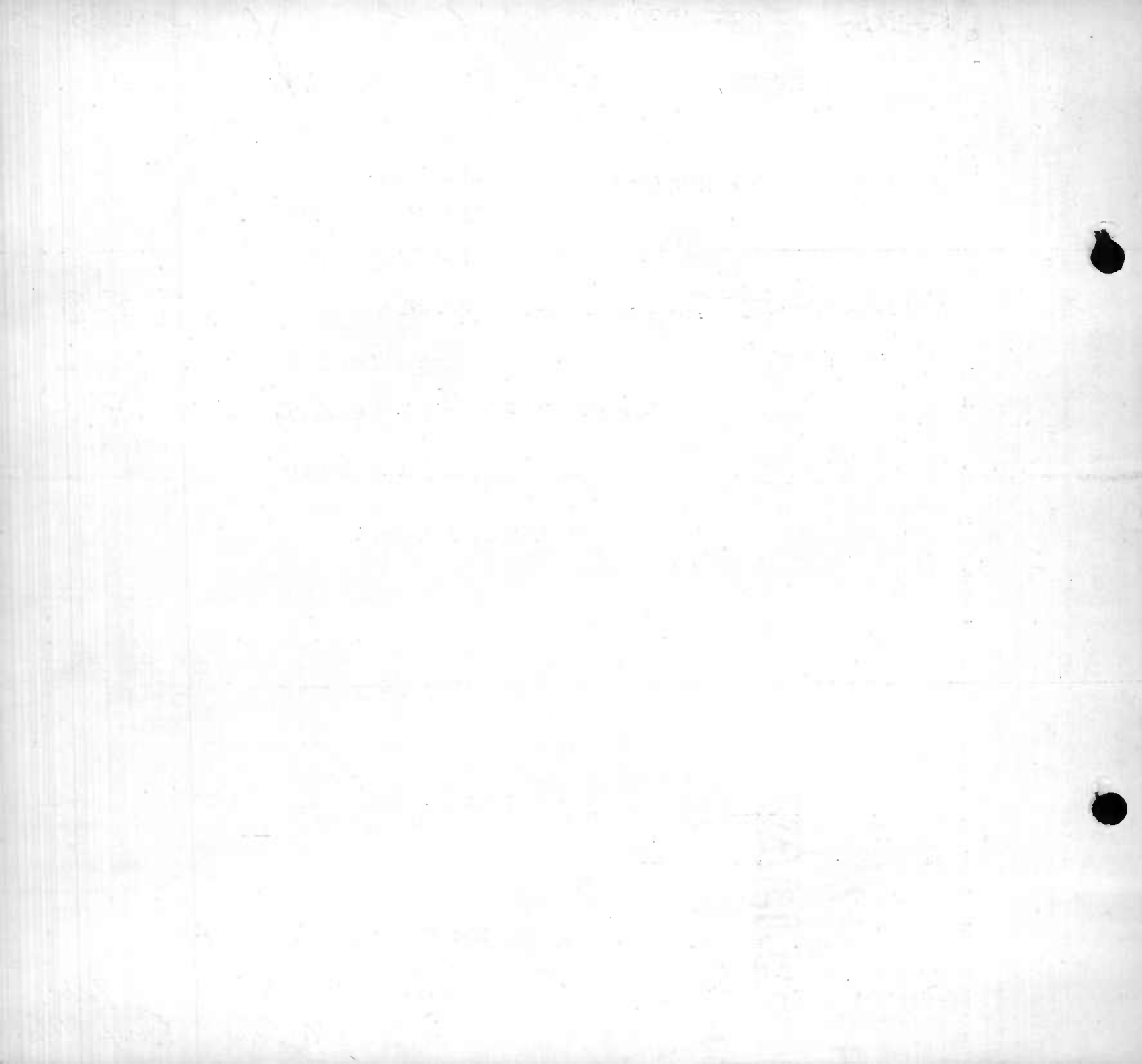
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed.

Released as non-medical examiner's case by Dr. Kornblum of Medical Examiner's Office

K-540		68- 4936		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 4936	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				KIMMEL, Andrew J.			
2. DATE AND HOUR OF DEATH				May 10, 1968   2:25 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
The Johns Hopkins Hospital				Maryland Baltimore Co 53-00			
5. SEX				6. RACE			
Male				White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				02-09-36			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Telephone Inst. Telephone Co.				Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Andrew Kimmel				Catherine Bender			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				216-30-0082			
17. INFORMANT				ADDRESS			
Ayaka Kimmel				(Same)			
18. 340 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF: (B) Multiple Sclerosis DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 3/12 19 68 to 5/10 19 68, that (I) (we) last saw the deceased alive on 5/10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Paul E. Michelson				23B. DATE SIGNED 5/10/68			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Paul E. Michelson				The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				5/14/68			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Oak Lawn Cem				Balto Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
MAY 13 1968				Robert E. Farley			
25C. FUNERAL DIRECTOR				ADDRESS			
J. E. Connelley Sons				Essex Md.			





1  
W-452

68- 4937 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4937

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

EARL

L.

WILLIAMS

2. DATE  
OF  
DEATHKnown ☐

Month

Day

Year

Hour

Estimated ☒

May

7,

1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

Union Memorial Hospital (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

May

7,

1968

7:42 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

white

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

July 10, 1916

10. AGE (In years  
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.

Months

Days

Hours

Min.

E. STREET AND NUMBER

809 W. 38th St.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Walter C.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Warehouseman

14B. KIND OF BUSINESS OR INDUSTRY

Coca Cola Co.

15. MOTHER'S MAIDEN NAME

Minnie G.

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W.II

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Minnie G. Williams 809 W. 38th St.

19. 011,9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Pulmonary Tuberculosis

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

002,1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/7/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

May 10, 1968

24C. NAME of CEMETERY or CREMATORY

Balto. Nat

24D. LOCATION

(City, town, or county)

(State)

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 13 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

ADDRESS

Paul E. Chenoweth Jr. 3617 Chestnut Ave.

1. The first part of the document is a list of names and addresses of the members of the committee.

2. The second part of the document is a list of names and addresses of the members of the committee.

3. The third part of the document is a list of names and addresses of the members of the committee.

4. The fourth part of the document is a list of names and addresses of the members of the committee.

5. The fifth part of the document is a list of names and addresses of the members of the committee.

6. The sixth part of the document is a list of names and addresses of the members of the committee.

7. The seventh part of the document is a list of names and addresses of the members of the committee.

8. The eighth part of the document is a list of names and addresses of the members of the committee.

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11. The eleventh part of the document is a list of names and addresses of the members of the committee.

12. The twelfth part of the document is a list of names and addresses of the members of the committee.

13. The thirteenth part of the document is a list of names and addresses of the members of the committee.

14. The fourteenth part of the document is a list of names and addresses of the members of the committee.

15. The fifteenth part of the document is a list of names and addresses of the members of the committee.

16. The sixteenth part of the document is a list of names and addresses of the members of the committee.

17. The seventeenth part of the document is a list of names and addresses of the members of the committee.

18. The eighteenth part of the document is a list of names and addresses of the members of the committee.

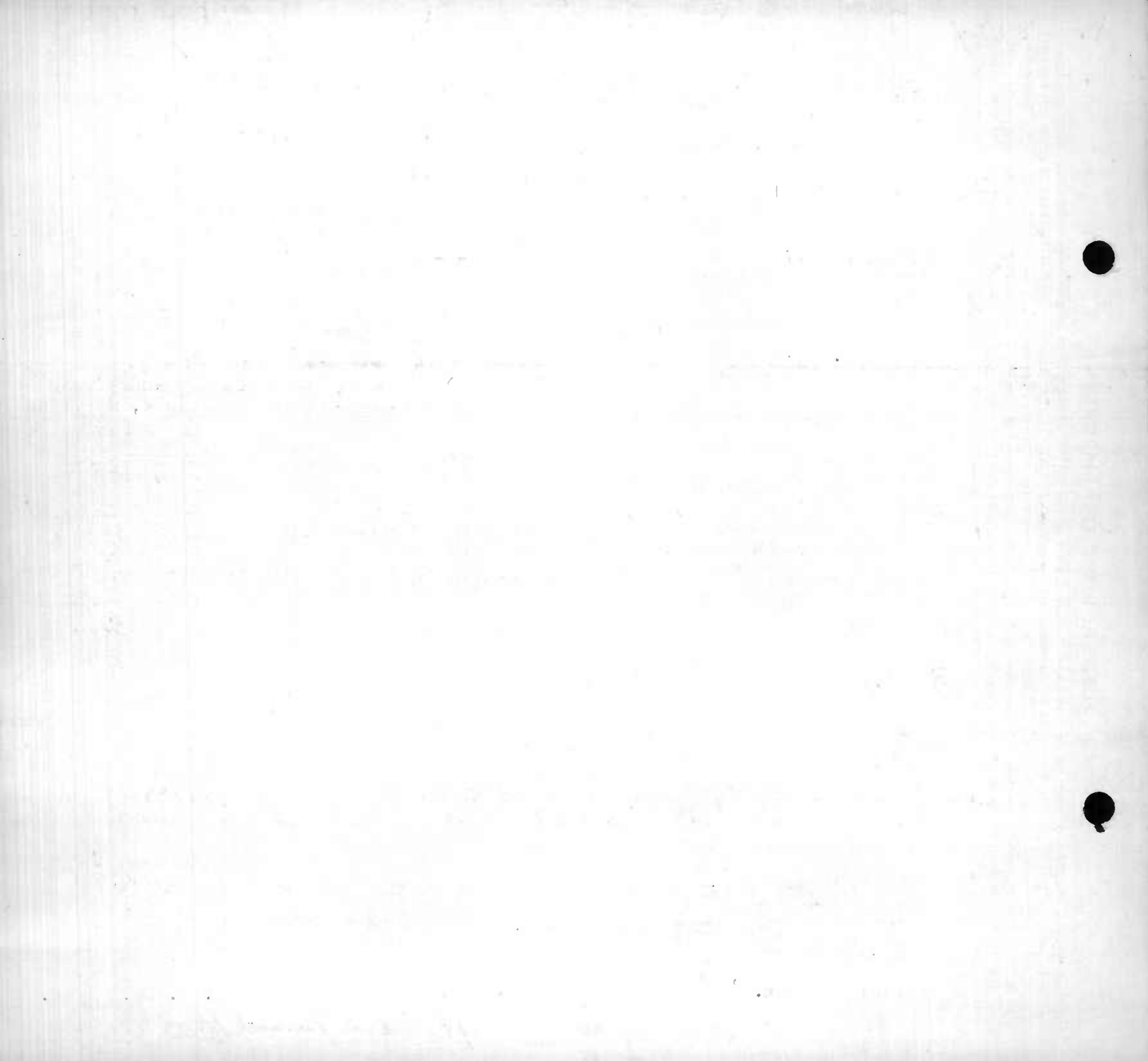
19. The nineteenth part of the document is a list of names and addresses of the members of the committee.

20. The twentieth part of the document is a list of names and addresses of the members of the committee.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-08251 68-4938				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4938	
1. NAME OF DECEASED (Type or Print) <b>Lori Anne Marcellas</b> <b>BABY GIRL MARCELLAS</b>				2. DATE AND HOUR OF DEATH <b>5/8/68 5:10 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE Co</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1535 Duxbury Rd</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-3-68</b>	9. AGE (In years lost birthday) <b>5</b>	If Under 1 Yr. Months: <b>5</b> Days: <b>5</b> Hours: <b>5</b> Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>THOMAS W. MARCELLAS</b>				14. MOTHER'S MAIDEN NAME <b>FAYE HARDESTY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Thomas W. Marcellas</b>		ADDRESS <b>1535 Duxbury Road Towson 4, Maryland</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>HYPERKALEMIA</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>CONGENITAL ARTERIOVENOUS FISTULA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>36 hrs</b> <b>4 days</b>	
19. DATE OF OPERATION <b>5/6/68</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CONGENITAL A-V FISTULA</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>the</del> <b>this hospital</b> attended the deceased from <b>5/5/68</b> 19 to <b>5/8/68</b> 19, that <del>the</del> <b>(we)</b> last saw the deceased alive on <b>5/8/68</b> 19 and that in <del>my</del> <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>not</del> view the body after death.							
23A. SIGNATURE <b>Stephen H. Polmar M.D.</b>				23B. DATE SIGNED <b>5/8/68</b>		23C. PHYSICIAN'S NAME (Type) <b>STEPHEN H. POLMAR M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>May 9, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Friendship Chr. Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Hutchins Funeral Home Owings, Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Friendship A. A. Co. Md.</b>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 4939 CERTIFICATE OF DEATH

REG. NO. 68- 4939

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MORGAN HUTCHISON</b>		2. DATE AND HOUR OF DEATH <b>5/8/68 2:55 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Carroll Co.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. OF MD. HOSPITAL</b>			C. CITY OR TOWN <b>MT. AIRY</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>Rt. #2</b>		
5. SEX <b>M</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/15/88</b>	9. AGE (In years lost birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>JOSEPH Hutchison</b>		
14. MOTHER'S MAIDEN NAME <b>ELIZA Simms</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>705-09-0198</b>			17. INFORMANT <b>Miss Maria V. Hutchison</b>		
ADDRESS <b>Same As #4</b>			18. CAUSE OF DEATH <b>4/10.9 I</b>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>CARDIAC ARRHYTHMIA</b> DUE TO, OR AS A CONSEQUENCE OF: <b>1-2 hrs</b>		
(B) <b>PROB. ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: <b>1-2 hrs</b>			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>4/20.1 II</b>			<b>THROMBOSIS @ MIDDLE CEREBRAL ART.</b> <b>2 wks</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/24 1968</b> to <b>5/8 1968</b> , that (I) (we) lost saw the deceased alive on <b>5/8 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ronica M. Kluge, M.D.</b>				23B. DATE SIGNED <b>May 8, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>RONICA M. KLUGE, M.D.</b>				23D. ADDRESS <b>UNIV. HOSPITAL BALT., MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Zion Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Carroll Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>C. M. Waltz, Box 241, Sykesville, Md.</b>			

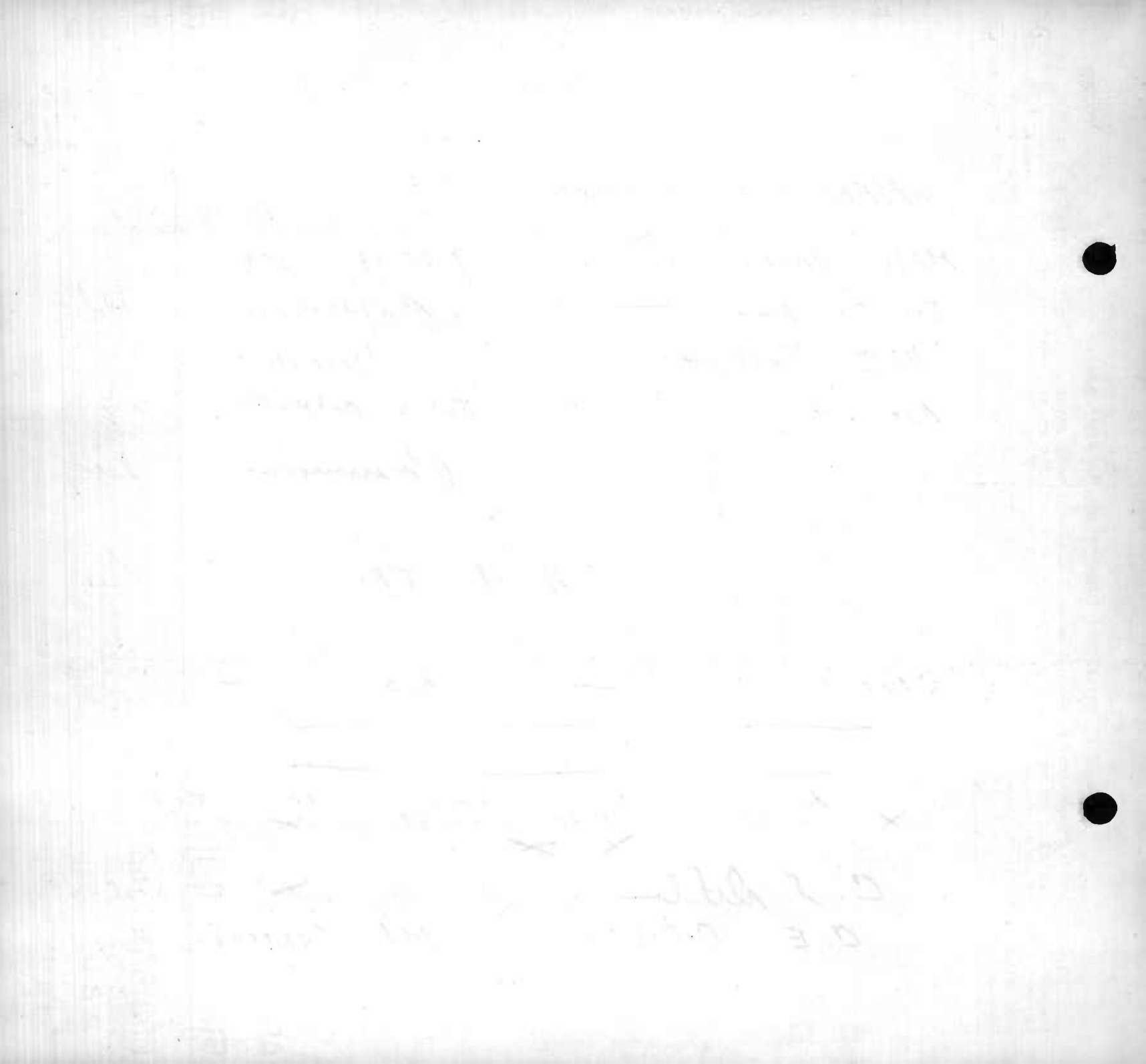




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4940			
1. NAME OF DECEASED (Type or Print)						2. DATE AND HOUR OF DEATH					
John W. Bothoff						5-8-68 3:00 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						C. CITY OR TOWN D. INSIDE CITY LIMITS?					
48 MARYLAND General						MARYLAND Baltimore YES NO					
E. STREET AND NUMBER						F. INSIDE CITY LIMITS?					
331 S. Bouldin St						YES NO					
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
MALE		CAUC				9-28-13		5-4			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Sec. Sec. Admin				—				Baltimore			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Md.				Wm Bothoff				Wilhemena Wiercks			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
No				212-05-8718				Julia Bothoff			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
486X I + 011.9				Pneumonia				Days			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(C) Hx of TBC				(D) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				493X II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
None				—				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examination)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				—			
22. I certify that (X) (this hospital) attended the deceased from 5-6 19 68 to 5-8 19 68, that (X) (we) last saw the deceased alive on 5-8 19 68 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (and was) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
C. E. DeFelice								5-8-68			
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
C. E. DeFelice								Md. General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
Burial				5-11-68				New Cathedral Cemetery Baltimore, Md.			
24D. LOCATION (City, town, or county) (State)				25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
Baltimore, Md.				MAY 13 1968				Robert E. Jenkins			
25C. FUNERAL DIRECTOR				25D. ADDRESS				25E. ADDRESS			
Nicholas T. Matthews				3021 Eastern Ave., Baltimore, Md.				—			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4941
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">FLORENCE J. LONDON</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">5/10/68</span> <span style="float: right;">6:10 P.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">PALL MALL NURSING HOME</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">3321 VIRGINIA AVENUE #21215</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">FEMALE</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">WHITE</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">69</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">69</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">AT HOME</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">LITHUANIA</span>
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">LAZIER WOOLF</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">ESTHER HEYMAN</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">216-05-1906</span>		
<b>17. INFORMANT</b> <span style="font-size: 1.2em;">MR. HARRY M. LONDON, 2700 EANEY ROAD #21209</span>		<b>ADDRESS</b> <span style="font-size: 1.2em;">#21209</span>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		<b>CAUSE OF DEATH</b> <span style="font-size: 1.2em;">RETICULUM CELL CARCINOMA WITH METASTASES</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">200.0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">II</span>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>21F. HOW DID INJURY OCCUR?</b>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">APRIL 19, 1968</span> <b>to</b> <span style="font-size: 1.2em;">MAY 10, 1968</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">MAY 10, 1968</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Marvin Goldstein, M.D.</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">MAY 10, 1968</span>		
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">MARVIN GOLDSTEIN</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">6001 PARK HEIGHTS AVE. BALTO., MD.</span>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">BURIAL</span>	<b>24B. DATE</b> <span style="font-size: 1.2em;">5-12-68</span>	<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">RIGA KURLANDER VAREIN</span>	<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">ROSEDALE, MARYLAND</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAY 19 1968</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Faldut</span>		
<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>		<b>ADDRESS</b>		

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-4942
H-200		68-4942		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Hess, Edna EVA		5/11/1968		2:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
Singer Hospital of Baltimore		Maryland Baltimore 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		810 Hopewood Rd. #21208			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/18/1924	43 y 10.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		AT HOME		BALTIMORE, MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
SAMUEL PHILLIP SNYDER		BESSIE BROOKS		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				MR. MAX HESS, 810 HOPEWOOD RD. #21208	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Respiratory Failure			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		Terminal Metastatic Ca. of Breast			
		(C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
170X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/10 1968 to 5/11 2000 1968, that (I) (we) last saw the deceased alive on 5/11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. Meyer Heller MD				5/11/1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J. Meyer Heller MD				Singer Hospital of Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify)		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		ANSHE EMUNAH AITZ CHAIM		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 13 1968		Robert E. Finkbeiner		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

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68- 4943

BALTIMORE CITY HEALTH DEPARTMENT

68- 4943

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>R. SAMUEL VARNEY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 5 8 68 9:13 a. m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>City Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year May 8 1968 9:13 a. m.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH April 21, 1896		10. AGE (In years last birthday) 72 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give year or dates of service) yes W. V. 1		17. SOCIAL SECURITY NO. 233-22-5562	
15. MOTHER'S MAIDEN NAME Mary A. May		18. INFORMANT Mrs. Elizabeth Woody	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		ADDRESS 3818 Hudson St.	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 12, 1968	
24C. NAME OF CEMETERY or CREMATORY Chapman Cemetery		24D. LOCATION (City, town, or county) (State) Ivydale, W. Virginia	
25A. DATE REC'D BY HEALTH DEPT. MAY 13 1968		25B. NAME OF REGISTRAR Robert E. Salisbury	
25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy. (21225)	



WALLEY BURN

K-400

68- 4944 BALTIMORE CITY HEALTH DEPARTMENT

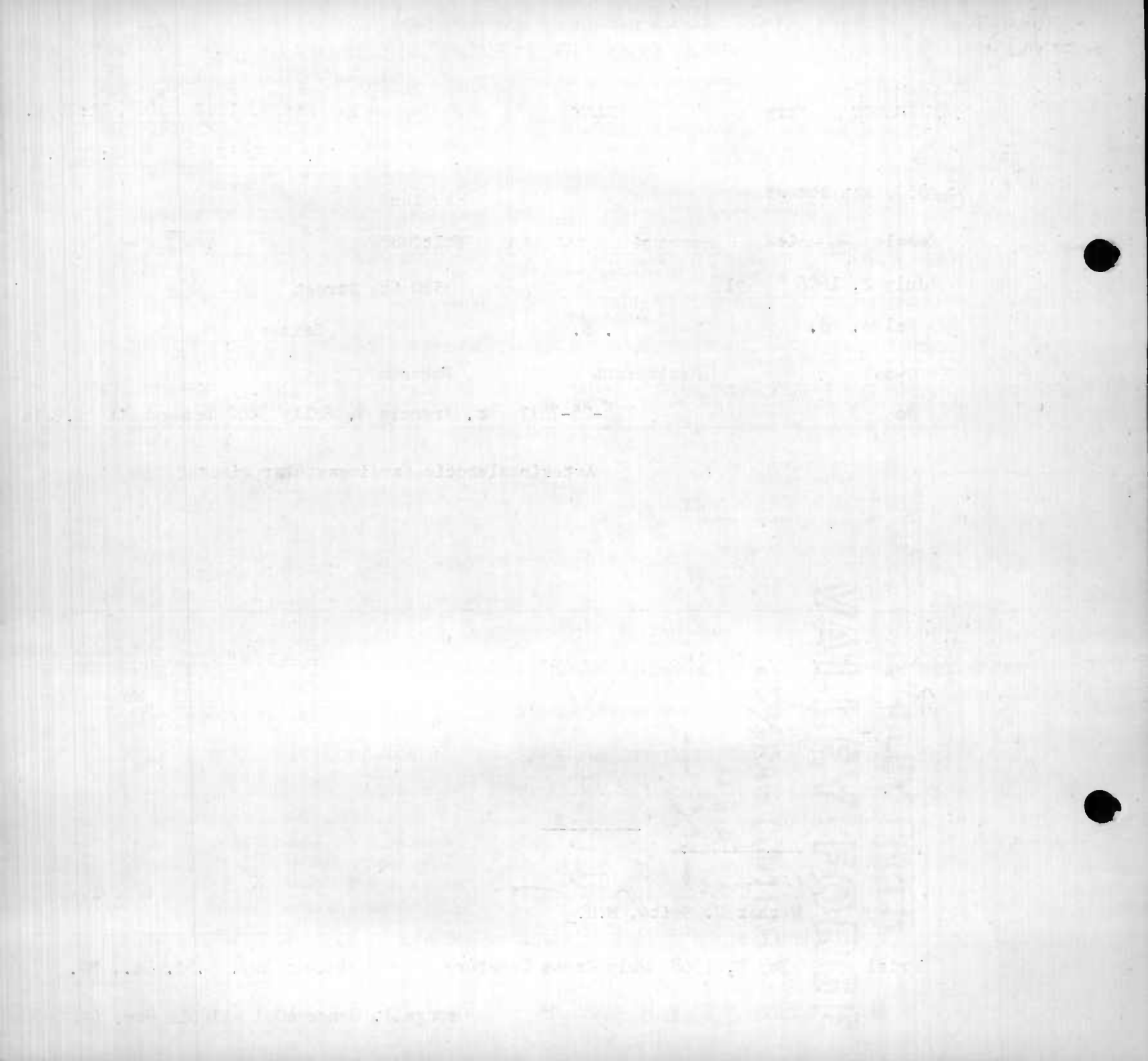
68- 4944

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARGARET Mary KELLY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>May 6, 1968</b> Hour <b>11:30 A.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3530 6th Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 6, 1968 2:25 P.M.</b>	
6. SEX <b>female</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>July 2, 1896</b>		10. AGE (In years lost birthday) <b>71</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-26-7417</b>	
18. INFORMANT <b>Mr. Francis T. Kelly</b>		ADDRESS <b>3802 Leadenhall St. Balt</b>	
19. <b>712.4</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>722.1</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) <b>No</b>	
ACTUAL SIGNATURE <b>Werner U. Spite, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Werner U. Spite, M.D.</b>		DATE SIGNED <b>5/7/68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 9, 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Hwy. A. A. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>	
25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hwy. (21225)</b>	



**FUNERAL DIRECTOR: IMPORTANT**

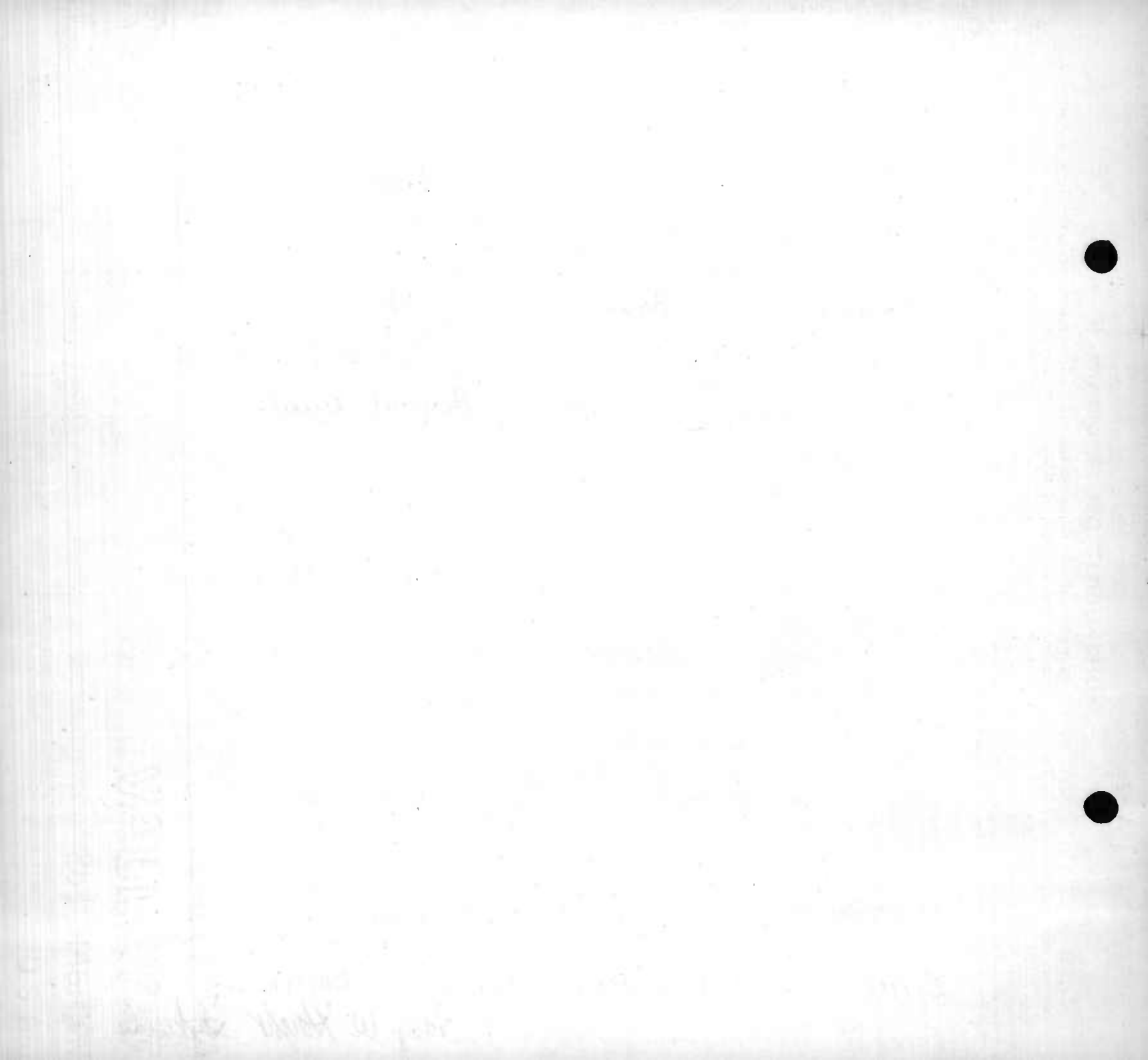
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 68- 4945 CERTIFICATE OF DEATH

REG. NO. 68- 4945

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MRS. CLARA BECKER</u>		2. DATE AND HOUR OF DEATH <u>5/7/68</u> <u>8:05P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Md. Gen. Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>8700 Cummins Circle, Balt. 34</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/5/97</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Charles. Wood</u>		14. MOTHER'S MAIDEN NAME <u>Julia E. Newton</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u>	
18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>422.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Edema</u> (B) <u>C.H.F. &amp; Ischemic</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Heart disease &amp; A.S.C.V.D.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/15/1968</u> to <u>5/7/1968</u> , that (I) (we) last saw the deceased alive on <u>5/7/1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. Swaroop</u>				23B. DATE SIGNED <u>5/7/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. SWAROOP</u>		23D. ADDRESS <u>MD. Gen. Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>5-10-68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Western Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 13 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Harry W. Knight</u>	
				ADDRESS <u>Luxville, Md.</u>	



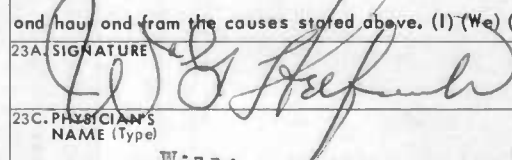
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4946

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 4946

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN LOUIS WARNER		May 8, 1968 <span style="float: right;">1045 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  2434 Brambleton Road				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2434 Brambleton Road	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1900	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instructor		10B. KIND OF BUSINESS OR INDUSTRY Telephone Co		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Louis J. Warner		14. MOTHER'S MAIDEN NAME Louise Schneider		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-03-6746		17. INFORMANT Mrs. Miriam Warner 2434 Brambleton Road.	
18. CAUSE OF DEATH					
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
(A) IMMEDIATE CAUSE Cerebral Vascular accident					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No)					
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 1950 to May 8, 1968, that (I) (we) last saw the deceased alive on May 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED May 10, 1968	
23C. PHYSICIAN'S NAME (Type) William G. Helfrich M.D.				23D. ADDRESS 5006 Roland Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/11/68		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikesville, Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 13 1968			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.			

Handwritten text, possibly a signature or name, located in the upper left quadrant.

Handwritten signature or name, located in the lower right quadrant.

Small handwritten mark or symbol, possibly a cross or 'x', located near the center of the page.

Handwritten text, possibly a date or number, located in the lower left quadrant.

Handwritten text, possibly a date or number, located in the lower left quadrant.

Handwritten text, possibly a date or number, located in the lower left quadrant.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4947

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 4947

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Ellen C. Crane</b>		2. DATE AND HOUR OF DEATH <b>5/7/1968</b> <b>1:15 AM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>158 S. Collins Ave.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>158 S. Collins Ave.</b>	
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/24/1895</b>	9. AGE (in years last birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Mary Farrell</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Walter T. Crane, 158 S. Collins Ave.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>MYocardial Infarction</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CORONARY ARTERY DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 YR</b>	
19. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>CARDIAC ARRYTHMIA</b>		<b>2 YR</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JULY 1952</b> to <b>MAY 7 1968</b> , that (I) (we) last saw the deceased alive on <b>APRIL 16 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>HERBERT W. LAPP, M.D.</b>		23B. DATE SIGNED <b>5/8/68</b>		23C. PHYSICIAN'S NAME (Type) <b>804 FREDERICK AVE. BALTIMORE 29, MD. - MI 4-3655</b>	
23D. ADDRESS		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>		25C. FUNERAL DIRECTOR ADDRESS <b>G. Truman Schwab, 3512 Frederick Ave., Balto. Md. 21229</b>	

My dear Sir

I have the pleasure to inform you

that the same has been forwarded

to the proper authorities for their consideration

Yours faithfully  
J. H. [Signature]

2/2/19

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-4948
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BARBARA M. BUTT		5/9/68 8 <sup>35</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
UNION MEMORIAL			BALT. 27-05		
44 BALT. MD			E. STREET AND NUMBER		
6705 EVERALL AVE.					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
F	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/4/94	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HSWF		HSWF		BALTIMORE	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
FREDERICK Necker		MATILDA FOOS		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		212-03-2058		MR. F. BUTT. son	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			ASPIRATION OF GASTRIC CONTENTS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHOLEDOCHOLITHIASIS (B) DUE TO, OR AS A CONSEQUENCE OF: STATUS POST CHOLEDOCHOLITHIASIS		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEVERAL HOURS SEVERAL MONTHS 2 WEEKS					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
5/24/68 Bile DUCT OBST. YES YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/9/68 to 5/9/68 that (I) (we) last saw the deceased alive on 5/9/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert R. Doyle MD				23B. DATE SIGNED 5/9/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Robert R. Doyle MD				Union Mem Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/13/68		Balto. Nat. Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 13 1968		Robert E. Farkner		Schimunek Funeral Home, Inc. 3331 Brehms Lane	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 4949

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)J.  
JOHN WERNSDORFER SR.2. DATE OF DEATH Known ☒ Estimated ☐  
Month Day Year Hour  
5 9 68 8:00 a. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital D.O.A. Maryland

3. DATE PRONOUNCED DEAD

May 9, 1968 8:00 a.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS

YES ☒ NO ☐

6. SEX

Male

7. RACE

White

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

E. STREET AND NUMBER

3430

2430 Ravenwood Ave.

9. DATE OF BIRTH

11/14/1908

10. AGE (In years last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Wernsdorfer

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Maintenance Supervisor

14B. KIND OF BUSINESS OR INDUSTRY

Sun Oil Company

15. MOTHER'S MAIDEN NAME

unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Ronald W. Wernsdorfer, son, above

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-9-68

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5/13/68

24C. NAME of CEMETERY or CREMATORY

Louson Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAY 13 1968

Ronald E. Farkas

Schimunek Funeral Home, Inc.  
3331 Brehms Lane

WALTER BORGER

Paul W. Keller

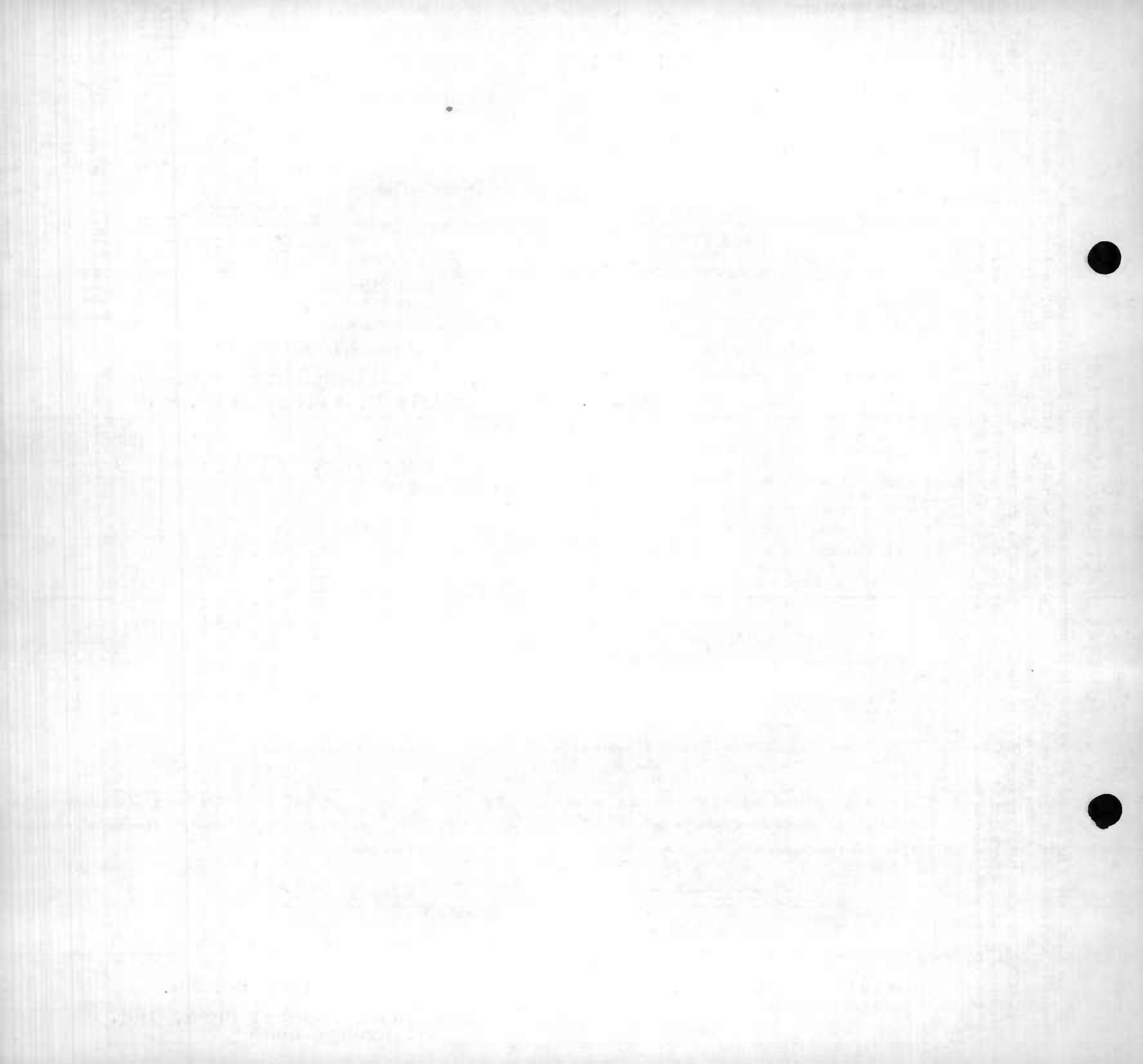
Paul W. Keller, N.Y.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Krieglstein ELIZABETH KRIEGLSTEIN</b>		2. DATE AND HOUR OF DEATH <b>May 9, 1968 2:00 M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHUREL HOME AND HOSP</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>	
				D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>537 N. LUZERNE AVE.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/5/1892</b>	9. AGE (In years lost birthday) <b>76</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore MARYLAND</b>	
13. FATHER'S NAME <b>Frank Cerny</b>			14. MOTHER'S MAIDEN NAME <b>Josephine Petrik</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-54-0376</b>		17. INFORMANT <b>3811 Shannon Drive Francis H. Krieglstein, son</b>	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Pneumonia, Atelectasis, Myocardial Ischemia</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A). <b>493X II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 3 19 68</b> to <b>May 9 19 68</b> , that (I) (we) lost saw the deceased alive on <b>May 9 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Veneracion</b> DEGREE				23B. DATE SIGNED <b>5/9/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>VENERACION</b> DEGREE				23D. ADDRESS <b>CHUREL HOME AND HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/13/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>MAY 15 1968</b>		25B. NAME OF REGISTRAR <b>Clara E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4951

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>BERTHA B. GRINNAN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>5 8 68 6:55 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2847 Huntingdon Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 8 1968 6:55 p.m.</b>	
6. SEX <b>Female</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b>	
7. RACE <b>White</b>		C. CITY OR TOWN <b>Balto.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>3/20/1886</b>		E. STREET AND NUMBER <b>2847 Huntingdon Ave.</b>	
10. AGE (In years last birthday) <b>82</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>?</b>		13. FATHER'S NAME <b>?</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rag Sorter</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Cleaning Cloth Co.</b>	
15. MOTHER'S MAIDEN NAME <b>?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>217-05-1986</b>		18. INFORMANT <b>Charles O Bradford</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>?</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>?</b> (C) DUE TO, OR AS A CONSEQUENCE OF: <b>?</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>422.1 II</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12-07</b>	
20A. DATE OF OPERATION <b>4-12-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>?</b>	
21. AUTOPSY? (Yes or No) <b>No</b>		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>?</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>?</b>	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>?</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>?</b>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5-9-68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Moreland Mem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Co.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Paul E. Chenoweth</b>	
25C. FUNERAL DIRECTOR <b>Paul E. Chenoweth</b>		ADDRESS <b>3615 Chestnut Ave.</b>	

X<sub>2</sub>

cc: [redacted] [redacted]

1997

51-66-29 LB

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4952	
BIRTH NO. <u>5-163</u>		68-4952	
1. NAME OF DECEASED (Type or Print) <u>Seifert, Timothy</u>		SEIFERT TIMOTHY	
2. DATE AND HOUR OF DEATH <u>5/8/68</u>		2:25 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND #21224</u>		A. STATE <u>Md</u> B. COUNTY <u>BALTIMORE</u>	
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>12-21-67</u> 9. AGE (In years lost birthday) <u>4</u> 10. BIRTHPLACE (State or foreign country) <u>Maryland</u> 11. CITIZEN OF WHAT COUNTRY? <u>USA</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 53-00	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		E. STREET AND NUMBER <u>830 Jaydee Ave #21222</u>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Seifert</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Cox</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>RECORDS: BALTIMORE CITY HOSPITALS</u>		ADDRESS <u>4940 Eastern Ave., Balto., Md. 21224</u>	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		<u>320.9 I</u> <u>Meningitis</u> <u>48 hrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5 AM 5/8</u> 19 <u>68</u> to <u>2:15 pm 5/8</u> 19 <u>68</u> . that (I) (we) last saw the deceased alive on <u>5/8</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Martin G. Myers MD</u>		23B. DATE SIGNED <u>5/8/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Martin G. Myers MD</u>		23D. ADDRESS <u>4940 EASTERN AVE. #21224</u> <u>Baltimore City Hosps Baltimore Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/11/68</u>	
24C. NAME OF CEMETERY or CREMATORY <u>HOLLY HILL</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 13 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>	
25C. FUNERAL DIRECTOR <u>J.E. CONNELLY SONS</u>		ADDRESS <u>306 MACE</u>	

Subject, [illegible] 2/1/57

Baltimore City Hosp. [illegible]  
No. 11

Infant  
Henry [illegible]  
Shirley Cox  
Maryland  
12-31-57

Men, [illegible]

40

2/8/57  
Baltimore City Hosp. Baltimore

Martin G. Myers MD  
Martin G. Myers MD

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RELEASED BY THE MEDICAL EXAMINERS OFFICE AS NON-MEDICAL MEDICAL CERTIFICATION

BALTIMORE CITY HEALTH DEPARTMENT  
68- 4953 CERTIFICATE OF DEATH

REG. NO. 68- 4953

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Peter H. Brown</b>		2. DATE AND HOUR OF DEATH <b>5/8/68 7:40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b>				C. CITY OR TOWN <b>White Marsh</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33</b>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>Box #182, Rt. #1</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/4/10</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic, Bus Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Automobile Service</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>MERVIN BROWN</b>			
14. MOTHER'S MAIDEN NAME <b>WENTZ</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK</b>			
16. SOCIAL SECURITY NO. <b>2 12-16-9863</b>		17. INFORMANT <b>Wife, Betty</b>		ADDRESS <b>Same</b>	
18. <b>1561 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Liver failure, acidosis, ascites, bile duct obstruction &amp; metastatic malignancy</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>Diabetes, Hypertension</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>1561 II</b>					
19A. DATE OF OPERATION <b>5/8/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BILE DUCT OBSTRUCTION</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>6 MAY 1968</b> 19 to <b>8 MAY 1968</b> , that (I) (we) lost saw the deceased alive on <b>8 MAY 1968</b> 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles O. Brantigan</b>				23B. DATE SIGNED <b>5/8/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES O. BRANTIGAN</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL BALTO. MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/11/68</b>		24C. NAME of CEMETERY or CREMATORY <b>OAK LAWN</b>	
24D. LOCATION <b>BALTO. MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>J.E. CONNELLY SONS</b>	
ADDRESS <b>300 MACE</b>					

1871

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4954	
<div style="display: flex; justify-content: space-between;"> <span>68- 4954</span> <span>CERTIFICATE OF DEATH</span> </div>					
<div style="display: flex; justify-content: space-between;"> <div> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Kapler, Alice V.</b> </div> <div> <b>2. DATE AND HOUR OF DEATH</b> <b>MAY 8, 1968 1:30 P.M.</b> </div> </div>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>33 The Johns Hopkins Hospital</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b>		
<b>5. SEX</b> <b>Female</b> <b>6. RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>3-26-96</b> <b>9. AGE</b> (In years lost birthday) <b>72</b>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>—</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>ITALY</b>		
<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>—</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>Joseph DiAngelis</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Marie Pelanegri</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			<b>16. SOCIAL SECURITY NO.</b> <b>—</b>		
<b>17. INFORMANT</b> <b>WM. R. KAPLER</b>			<b>ADDRESS</b> <b>ABOVE</b>		
<b>18. CAUSE OF DEATH</b>					
<b>18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  <b>18B. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>18C. CAUSE OF DEATH</b> <b>18C.1. IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>METASTATIC CARCINOMA</b> <b>18C.2. RECURRENT</b> <b>CARCINOMA OF THE CERVIX</b> <b>18C.3. PRIMARY CARCINOMA OF THE CERVIX</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 MONTHS</b> <b>7 YEARS</b> <b>28 YEARS</b>	
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>NONE</b>					
<b>19A. DATE OF OPERATION</b> <b>0 1961</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>RECURRENT CERVICAL CARCINOMA</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>NO</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <b>NO</b>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>—</b>	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <b>—</b>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <b>—</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 4/17 1968 to 5/8 1968, that (I) (we) last saw the deceased alive on 5/8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Dr. Edward Goldberg</b>				<b>23B. DATE SIGNED</b> <b>8 May 1968</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Dr. Edward Goldberg</b>				<b>23D. ADDRESS</b> <b>The Johns Hopkins Hospital</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>24B. DATE</b> <b>5/11/68</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>GARDENS OF FAITH</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>BALTO. MD.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 13 1968</b>			
<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Johnson</b>		<b>25C. FUNERAL DIRECTOR</b> <b>J.G. CONNELLY SONS</b>		<b>ADDRESS</b> <b>300 MALE</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4955

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO.

68- 4955

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Edith May Canapp</i>		2. DATE AND HOUR OF DEATH <i>May 9 1968 12-15 P</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>The Wesley Home</i> <i>90 2211 W Rogers Ave</i>				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Sept 6 1892</i>		9. AGE (In years last birthday) <i>75</i>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Enoch Fisher</i>		14. MOTHER'S MAIDEN NAME <i>Martha Strother</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212 10 24380</i>		17. INFORMANT <i>Wesley Home</i> ADDRESS <i>2211 W Rogers Ave</i>	
18. <i>443X II</i> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral hemorrhage</i>			
ANTECEDENT CAUSES		(B) <i>Hypertensive cardiovascular disease</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>5 years</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19 September 1967</i> to <i>9 May 1968</i> , that (I) (we) last saw the deceased alive on <i>9 May 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John W Barnaby M.D.</i>				23B. DATE SIGNED <i>10 May 68</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOHN W BARNABY</i>				23D. ADDRESS <i>1531 E North Ave</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>5-11-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greenmount Crematory</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. (State) <i>MD</i>		24F. (Country) <i>USA</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 13 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Burgess Funeral Home</i> ADDRESS <i>Baltimore</i>	



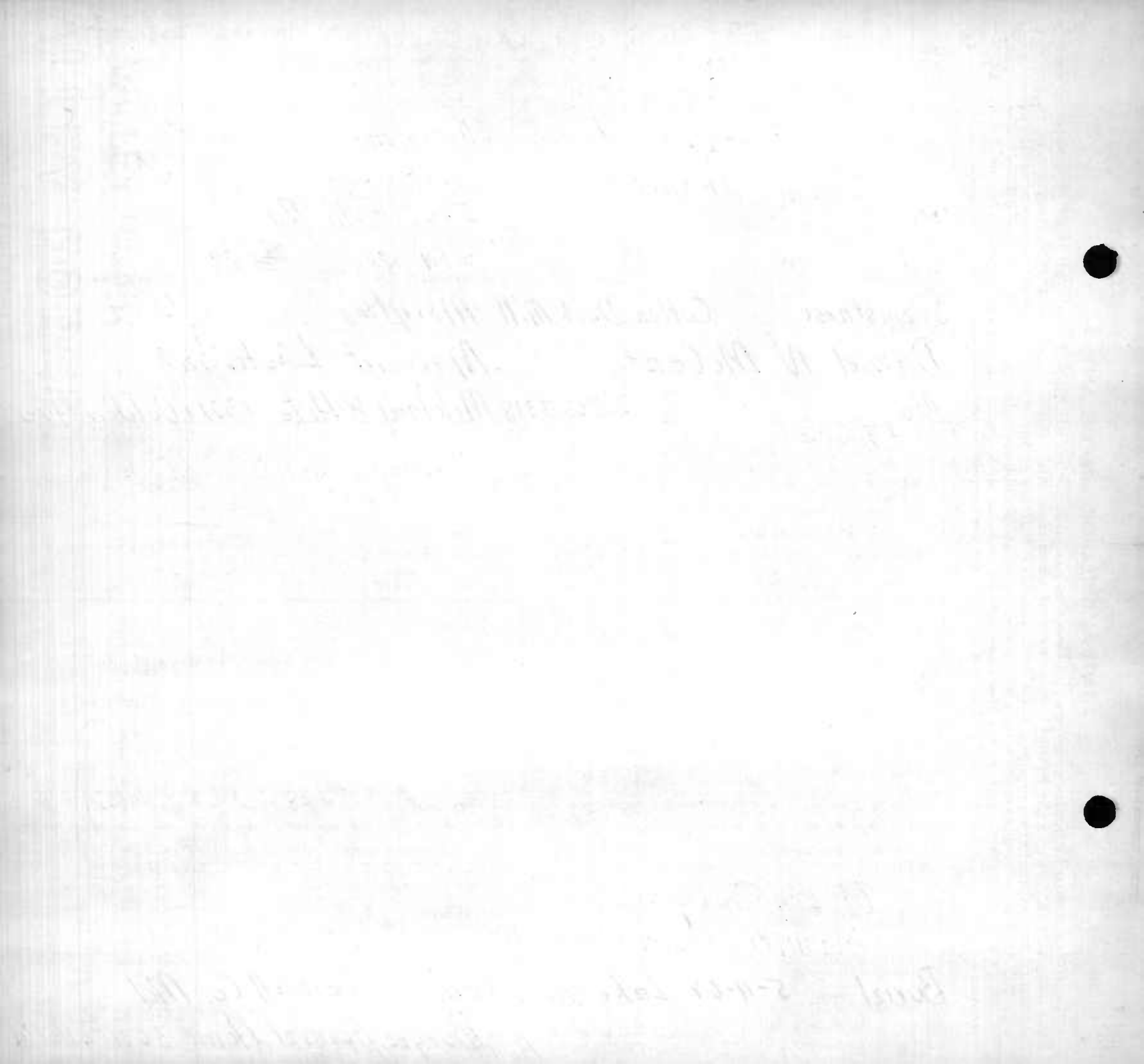
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 4956 CERTIFICATE OF DEATH

REG. NO. 68- 4956

BIRTH NO. 68- 4956		1. NAME OF DECEASED (Type or Print) <u>McCarty, Mary Ann</u>		2. DATE AND HOUR OF DEATH <u>May 8, 1968</u> <u>7 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>42 Sinai Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>5805 Falls Rd</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/1880</u>	9. AGE (In years lost birthday) <u>87</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Cotton Duck Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Daniel N McCarty</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Lauterbach</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>21303 3338</u>		17. INFORMANT <u>Michael K Hite</u> ADDRESS <u>1321 Weldon Ave</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>42.31</u> <u>CORONARY A.S.H.D.</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary A.S.H.D.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 8</u> 19 <u>68</u> to <u>May 8 (noon)</u> 19 <u>68</u> . that (I) (we) last saw the deceased alive on <u>May 8</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Myung Sun Yoon, M.D.</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>MYUNG SUN YOON, M.D.</u>		23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-11-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lake View Cem</u>	
24D. LOCATION <u>Conroll Co Md</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>MAY 13 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>Burgess Funeral Home</u>		ADDRESS <u>3631 Falls Rd</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 4957

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Dolores A. Bangs</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>5</b> Day <b>7</b> Year <b>68</b> Hour <b>8:00</b> p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTO. CITY HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month <b>May</b> Day <b>7</b> Year <b>1968</b> Hour <b>8:00</b> p.M.	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Dundalk</b> <b>Balto.</b>	
9. DATE OF BIRTH <b>July 27, 1930</b>		10. AGE (In years lost birthday) <b>37</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>212-28-0122</b>	
15. MOTHER'S MAIDEN NAME <b>Helen Wloczewski</b>		18. INFORMANT (Husband) <b>Earl R. Bangs, 909 Oakleigh Beach Rd.</b>	
19. <b>E 8169</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Multiple traumatic injuries</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22D. TIME OF INJURY (APPROX.) <b>5</b> <b>68</b> <b>11:00</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Quaker Hill Rd.</b>		22F. HOW DID INJURY OCCUR? <b>Subject in auto which struck telephone pole</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> *Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		DATE SIGNED <b>5/8/68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Bel Air Memorial Gardens</b>		24D. LOCATION (City, town, or county) (State) <b>Bel Air, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>John J. Duda</b>	
25C. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		ADDRESS	



Paul M. K...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RELEASED ON APPROVAL FOR THE MEDICAL EXAMINER'S OFFICE BY DR. WILSON

68- 4958				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 4958	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HEPNER, Gertrude</b>				2. DATE AND HOUR OF DEATH <b>May 9, 1968</b>		7:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33</b> <b>The Johns Hopkins Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Towson</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/20/86</b>	
9. AGE (In years last birthday) <b>81</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hepner</b>				14. MOTHER'S MAIDEN NAME <b>Rose E. Reisner</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>033-26-1125</b>		17. INFORMANT <b>Dr. Walter Sheldon</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MASSIVE MYOCARDIAL INFARCTION</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24-48 hrs</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>SEVERE BILATERAL BRONCHOPNEUMONIA</b>				DUE TO, OR AS A CONSEQUENCE OF: <b>?</b>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Fracture of hip</b>							
21A. DATE OF OPERATION <b>4/08/68</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fractured Hip (Left)</b>		22A. AUTOPSY? (Yes or No) <b>Yes</b>		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
23A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		23B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		23C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>646 Charles St. Ave</b>		53-00	
24D. TIME OF INJURY (APPROX.) <b>Jan. 8, 1968</b>		24E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		24F. HOW DID INJURY OCCUR? <b>Patient Fell</b>			
25. I certify that (I) (this hospital) attended the deceased from <b>Jan. 8</b> 19 <b>68</b> to <b>May 9</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>May 9</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
26A. SIGNATURE <b>R. Patterson Russell</b>				26B. DATE SIGNED <b>May 9, 1968</b>			
27C. PHYSICIAN'S NAME (Type) <b>Dr. R. Patterson Russell</b>				27D. ADDRESS <b>The Johns Hopkins Hospital</b>			
28A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		28B. DATE <b>5/10/68</b>		28C. NAME OF CEMETERY or CREMATORY <b>Greenmount Crematory</b>		28D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
29A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		29B. NAME OF REGISTRAR <b>Robert E. Farkas</b>		29C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks</b>		29D. ADDRESS <b>Towson 1050 York Rd.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 4959

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DOROTHY WINTERS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>5 8 68 9:15 a. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 8, 1968 9:15 a. M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>2-20-1915</b>		10. AGE (In years lost birthday) <b>53</b>	
11. BIRTHPLACE (State or foreign country) <b>Emmitsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Eyler</b>		14. MOTHER'S MAIDEN NAME <b>Ella Caldwell</b>	
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b>		B. COUNTY <b>9-08</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>No</b>	
18. INFORMANT <b>Charles C. Winters ( Same As Above)</b>		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Overdose of Barbiturate</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>E970.2 II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Overdose of Barbiturate</b>	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>E970.2 II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Overdose of Barbiturate</b>	
22. DATE OF OPERATION <b>2</b>		23. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
26. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>188 E. 33rd Street</b>		27. HOW DID INJURY OCCUR? <b>Overdose of Barbiturate</b>	
28. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>5 7 68 P. m.</b>		29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		25. DATE <b>5-11-1968</b>	
26. NAME OF CEMETERY or CREMATORY <b>BALTIMORE Cem.</b>		27. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
28. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		29. NAME OF REGISTRAR <b>Robert E. Farber</b>	
30. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc. Balto., Md. 21202</b>		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

68- 4950

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4950

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Nellie Hunt		5- 8- 1968 1:02 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
90 Gould Conves. Home 6116 Belair Road 21206				Md. C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				Box 398 Baltimore Md. 21220	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	Cauc.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3-31-1881	87	Piano Teacher
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Piano Teacher		Housewife	Baltimore Co. Md.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Christian Hearn			Sarah Rhoades		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Np			Mrs Blanche Zeller Rt#16 Box398 21220		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral hemorrhage		6 weeks	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic C-V disease associated			
		(C) Chronic myocarditis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan 13 19 65 to May 8 19 68, that (I) (we) last saw the deceased alive on May 7, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
H. V. Harbold MD				May 19, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
H. V. HARBOLD MD				4706 Harford Road Baltimore 21214	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5-11-1968		Moreland Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 13 1968		Robert E. Finkbeiner		Lassahn Funeral Home 7401 Belair Road	

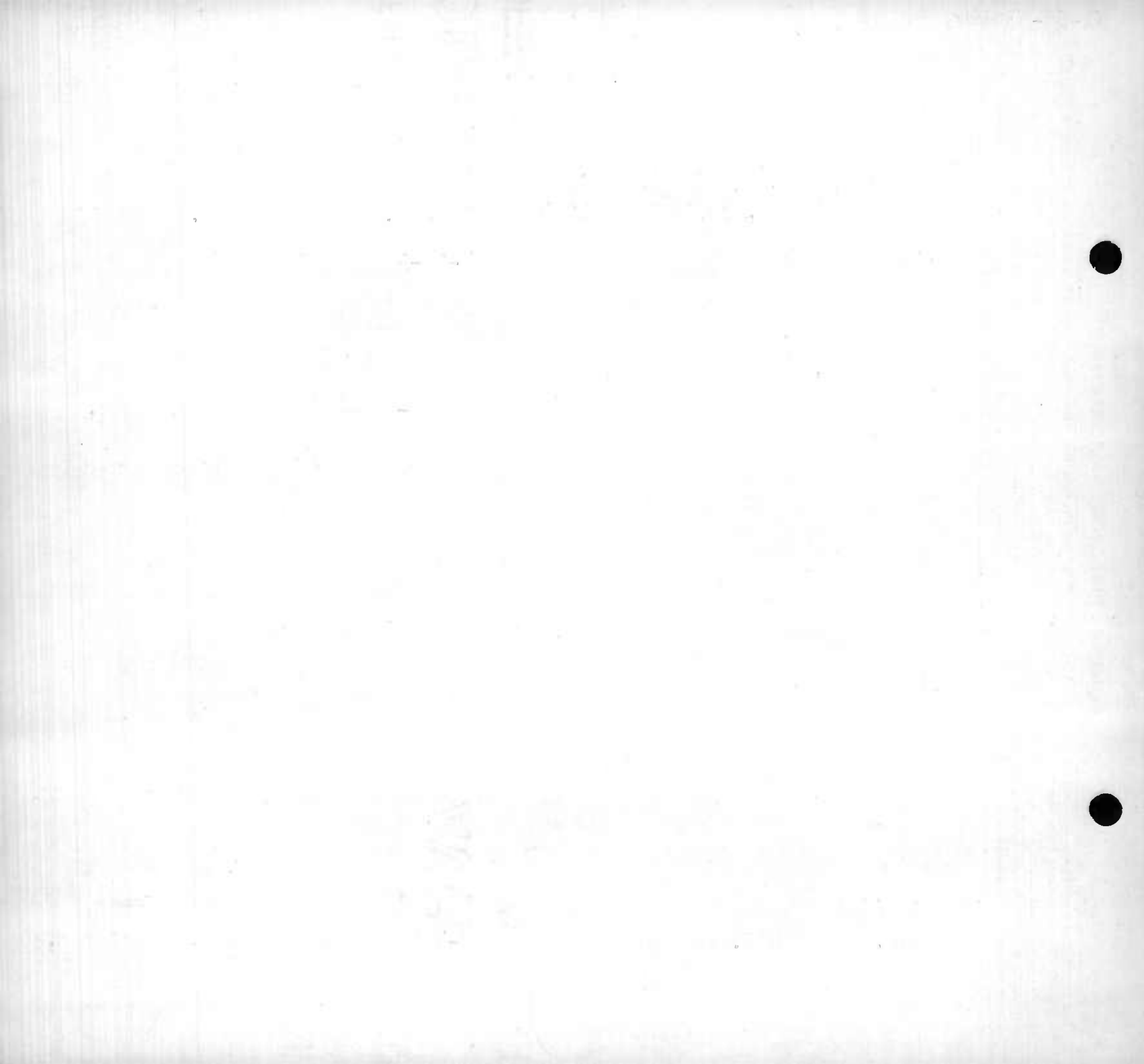




## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ALBERT BROWN		May 9, 1968 8:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE	
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				B. COUNTY	
31				MARYLAND	
				C. CITY OR TOWN	
				BALTIMORE	
				D. INSIDE CITY LIMITS	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
1726 N. WASHINGTON ST.				#21213	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-29-38	30	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Sparrows Point		SOUTH CAROLINA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
JOHN		FLOSSIE MCGILL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		219-32-6690		ADDRESS	
				RECORDS-BCH-4940 EASTERN AVENUE,	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		4 hrs.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
467.2 II		Marked debilitation, FUO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (this hospital) attended the deceased from May 6 1968 to May 9 1968, that (I) lost saw the deceased alive on May 9 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
DR. RAYMOND J. LASURE M.D.				May 9, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DR. RAYMOND J. LASURE				BCH-4940 EASTERN AVENUE, BALTIMORE, MD	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial-Transit	5-13-68	St. James Church Cemetery	Florence, South Carolina		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR			
MAY 13 1968	Robert E. Taylor	1735 Harford Ave. APPEB3 Baltimore, Md. Marshall W. Jones, Jr.			



# 68- 4962 CERTIFICATE OF DEATH

68- 4962 REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		STEVENS, Albert J		5/13/68 12:15 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
The Johns Hopkins Hospital				Delaware	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				George Town YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				228 South Bedford Sr.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years, lost birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7/12/01	66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Retired			clothing		MARYLAND
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Albert J. Stevens			Rebecca A. Smith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
Yes			UNKNOWN 275-05-7596		ALBERT J. STEVENS III DELAWARE
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
Myocardial Infarction 4 days					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
Following Surgery for abdominal aortic aneurysm					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
451X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
May 7, 1968		Abdominal Aortic Aneurysm		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) this hospital attended the deceased from April 26 19 68 to May 13 19 68, that (I) (we) last saw the deceased alive on May 12 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Coy Freeman MD				May 13, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Coy Freeman				The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5/16/68		UNION CEMETERY Georgetown Sussex DEL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 13 1968		Robert E. Taylor		William J. Echam J. Boy, Town Del.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. GEN REG 07

NO 100 IN 1000  
1000 IN 1000

NO 100 IN 1000  
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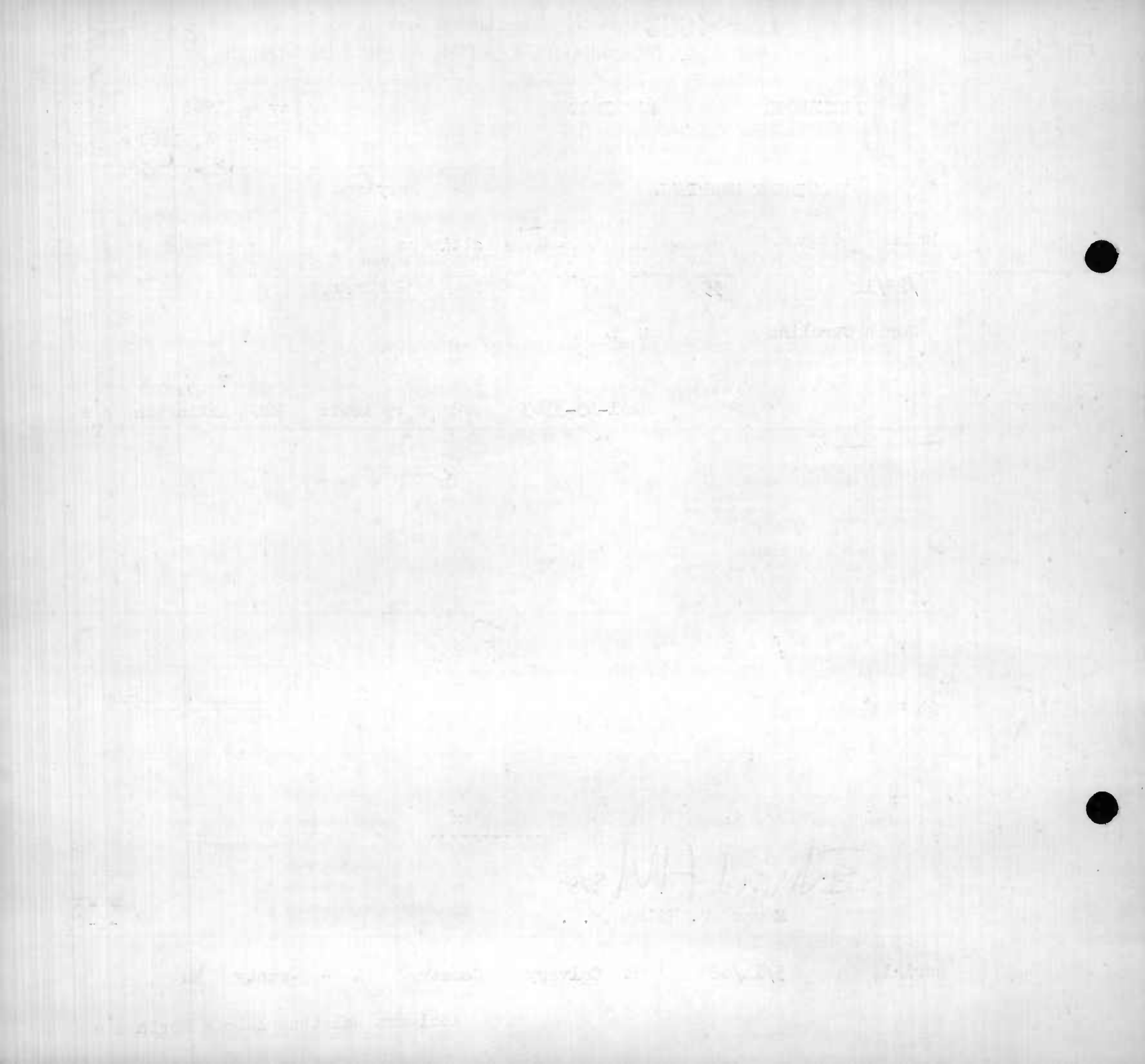
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 4963

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ALEXANDER HARRINGTON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 4, 1968</b> Hour <b>8:02 P.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) <b>39 PROVIDENT HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Year Day <b>May 4, 1968</b> Hour <b>8:02 P.</b> M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>9/23/12</b>	10. AGE (In years last birthday) <b>55</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>?</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>?</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>241-05-5563</b>	
18. INFORMANT <b>Mrs Mary Lewis</b>		ADDRESS <b>920 Arlington Ave</b>	
19. <b>571.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Acute &amp; chronic alcoholism</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20. DATE OF OPERATION <b>5-11-68</b>		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>5-5-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial,</b>	24B. DATE <b>5/11/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>R. E. G. Talley</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	



5-568

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **CORINNE SKINNER**

2. DATE AND HOUR OF DEATH **5/9/68 11:45 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE **MARYLAND** B. COUNTY **BALTIMORE**

5. SEX **Female** 6. RACE **Negro** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH **6/29/93** 9. AGE (In years last birthday) **74**

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 11. BIRTHPLACE (State or foreign country) **MARYLAND** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME **ELIZA**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT **RECORDS-BCH-4940 EASTERN AVENUE** ADDRESS

18. **450X I** DISEASE OR CONDITION DIRECTLY LEADING TO DEATH **Pulmonary Emboli** CAUSE OF DEATH  
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

19. DATE OF OPERATION 198. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **NO** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **10/13** to **5/9** 19**68**, that (I) (we) last saw the deceased alive on **5/9** 19**68** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE **Dr. M. Jafre** 23B. DATE SIGNED **5/9/68**

23C. PHYSICIAN'S NAME (Type) **DR. M. JAFRE** 23D. ADDRESS **BCH-4940 EASTERN AVENUE, BALTIMORE, MD**

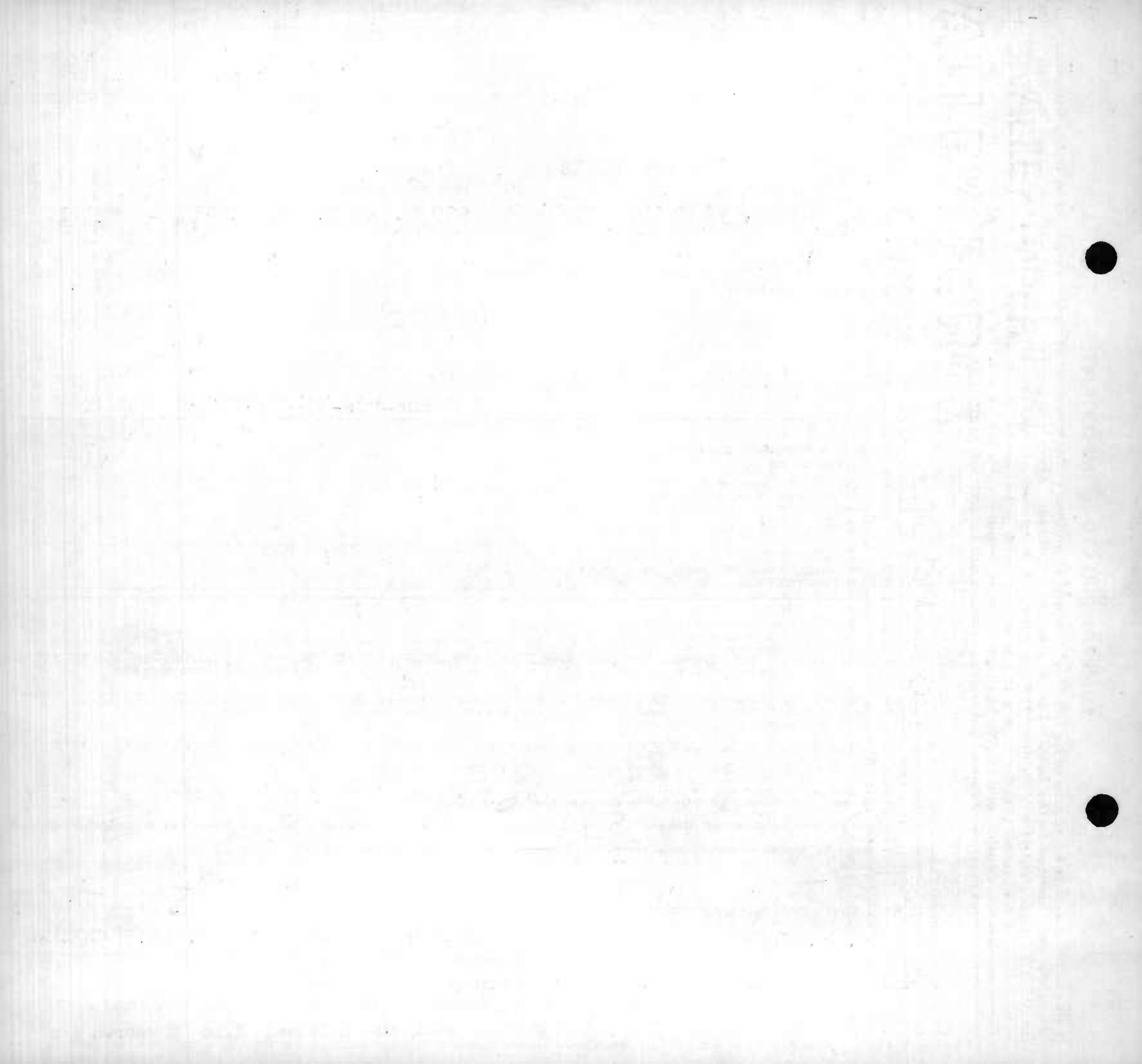
24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **5/15/68** 24C. NAME OF CEMETERY or CREMATORY **Mt Auburn Cemetery** 24D. LOCATION (City, town, or county) (State) **Baltimore Md**

25A. DATE REC'D BY HEALTH DEPT. **MAY 13 1968** 25B. NAME OF REGISTRAR **Robert E. Talley** 25C. FUNERAL DIRECTOR **Adolphus Halstead** ADDRESS **1206 W North Ave.**

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





FUNERAL DIRECTOR: IMPORTANT

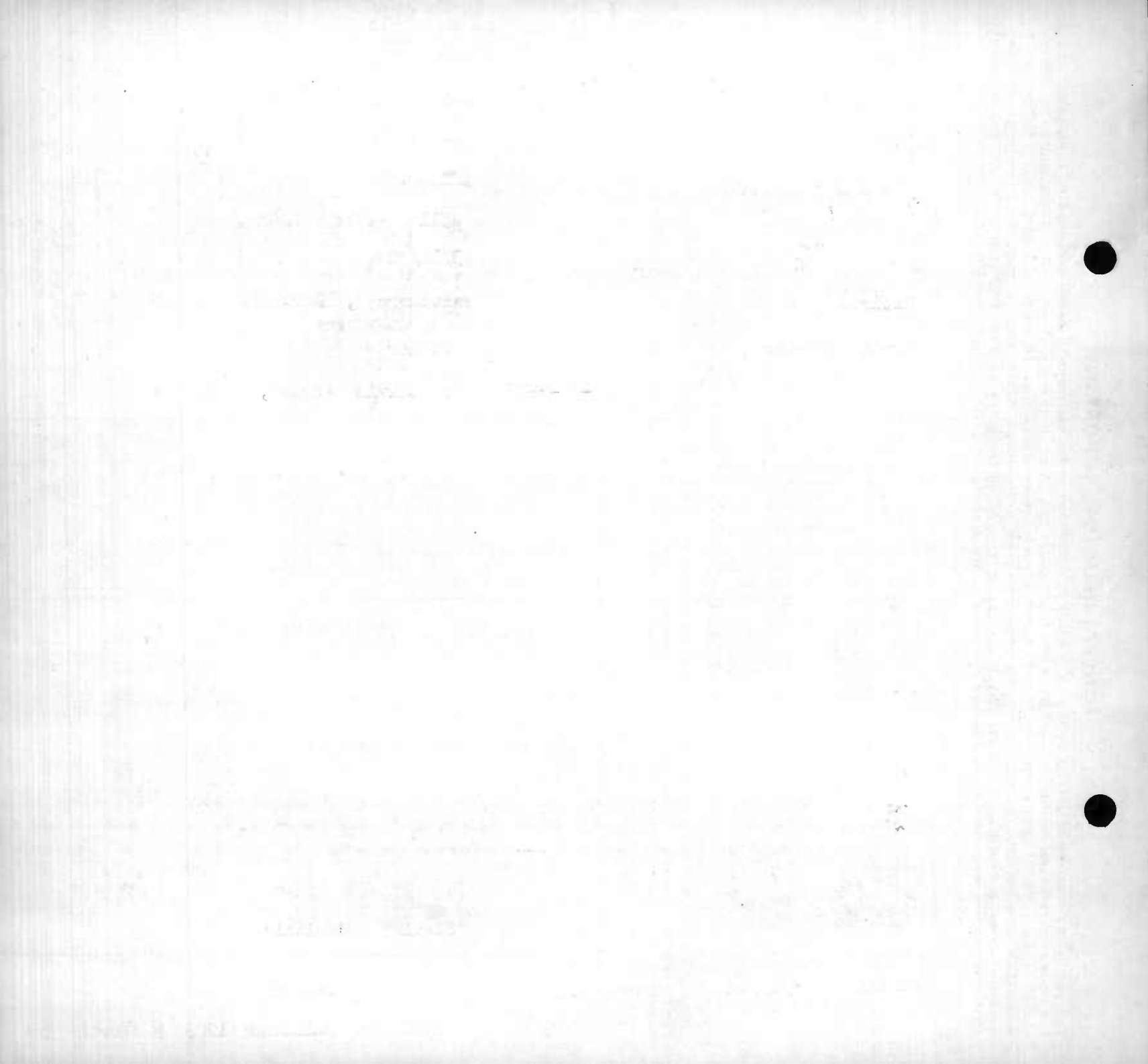
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-- 4965

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-- 4965

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Joseph Slater</b>		2. DATE AND HOUR OF DEATH <b>5/9/68</b>   <b>6<sup>25</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2511 EUTAW PLACE</b>		
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/12/92</b>	9. AGE (In years last birthday) <b>76</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Martin Slater</b>			14. MOTHER'S MAIDEN NAME <b>Tanner</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-10-9972</b>		17. INFORMANT <b>Mr Calvin Thomas, same</b>	
18. <b>203X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Myeloma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. <b>203X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(B)</b> (this hospital) attended the deceased from <b>2/29</b> 19 <b>68</b> to <b>5/9</b> 19 <b>68</b> , that <b>(H)</b> (we) last saw the deceased alive on <b>5/9/68</b> 19 <b>68</b> and that in <b>(M)</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <b>(Was)</b> (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b> M.D.			23B. DATE SIGNED <b>5/9/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Sinai Hospital</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/15/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Carver Mem Park</b>	
24D. LOCATION (City, town, or county) <b>Maryland</b>		24E. NAME OF REGISTRAR <b>Adolphus Halstead</b>		24F. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Ave</b>	
25A. DATE RECD BY HEALTH DEPT. <b>MAY 14 1968</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Ave</b>	



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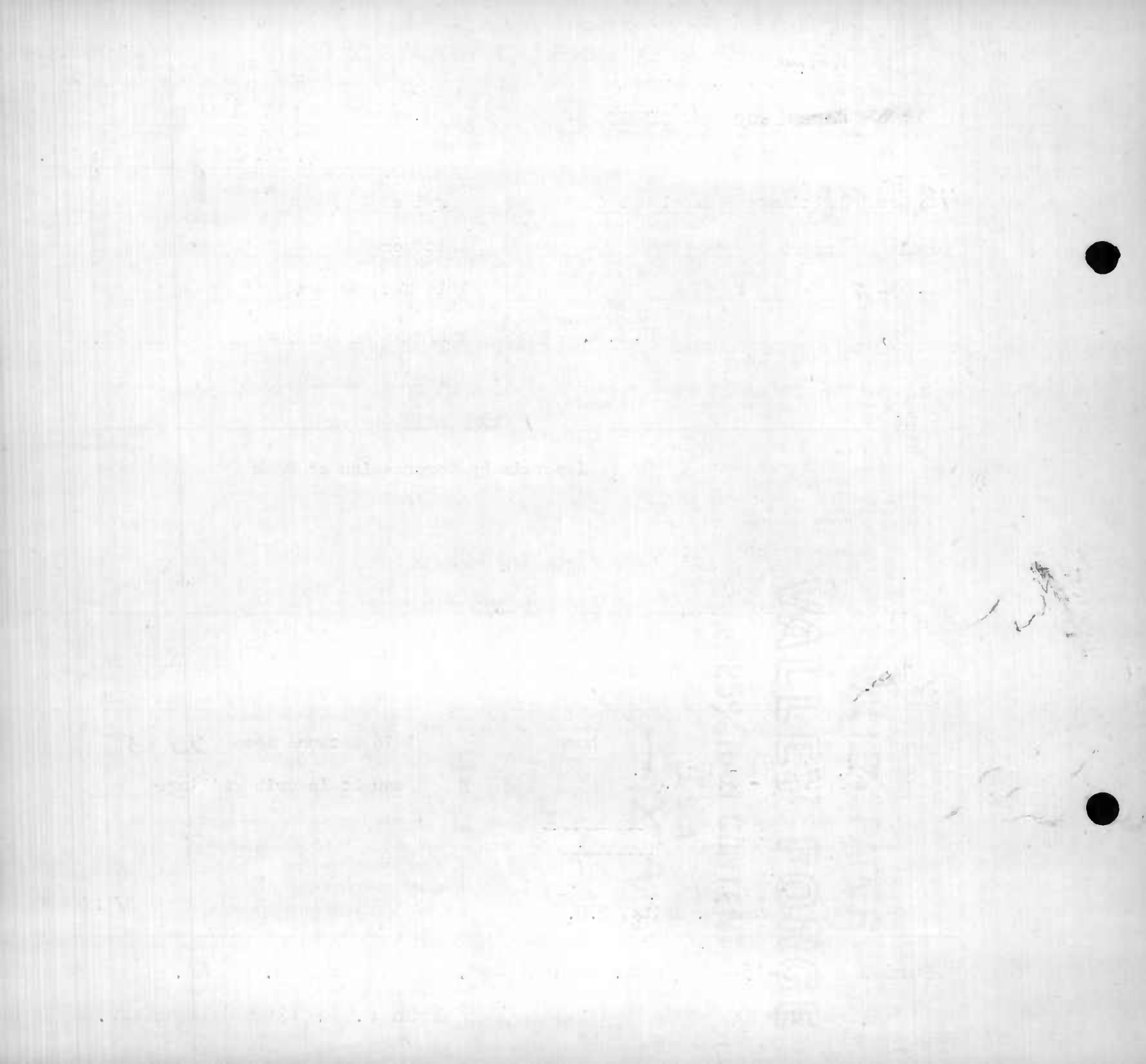
M-252 68-4966 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-4966

BIRTH NO. 67-07599

1. NAME OF DECEASED (Type or Print) Bernalene MC GINNIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> May 11, 1968	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour May 11, 1968 2:32 A.M.	
6. SEX female	7. RACE negro	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 4-20-67		E. STREET AND NUMBER 1016 Bethune Road	
10. AGE (In years lost birthday) 1		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wallace McGinnis	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Juanita Waden	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Wallace McGinnis		ADDRESS same	
19. CAUSE OF DEATH E913.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Asphyxia by Compression of Neck (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1016 Bethune Road 22D. TIME OF INJURY (Month, Day, Year, Hour, Minute) Bet 5/10/68 - 10:30 P & 5/11/68 - 2:32 A.M. 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 22F. HOW DID INJURY OCCUR? caught in crib railings			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. EXAMINER'S NAME (Type): CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 5/11/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-16-68	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 13 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Kelson F. H.		25D. ADDRESS 1348 Calhoun St.	

VS 151-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68-4967</span>	
<div style="display: flex; justify-content: space-between;"> <span><b>1. NAME OF DECEASED</b> (Type or Print)</span> <span><b>2. DATE AND HOUR OF DEATH</b></span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>Miller, Leroy NMN</b></span> <span><b>May 9, 1968</b> <span style="float: right;"><b>7:55 P.M.</b></span></span> </div>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd.</b> <b>Baltimore, Maryland 21218</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3108 Mondawmin AVE.</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10/25/25</b>	<b>9. AGE</b> (In years last birthday) <b>42</b>	<b>10. CITIZEN OF WHAT COUNTRY?</b> <b>United States</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Unknown</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>North Carolina</b>	
<b>13. FATHER'S NAME</b> <b>Fletcher Miller</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Amanda Griffith</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WWII</b>		<b>16. SOCIAL SECURITY NO.</b> <b>246-16-7731</b>		<b>17. INFORMANT</b> <b>Records</b> <b>Veterans Adm. Hosp. Balto., Md. 21218</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  <b>481X I</b> <b>Lobar pneumonia</b>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>4 Days</b>		
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.  <b>490X II</b> <b>Delirium Tremens</b>			<b>1 Day</b>		
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>No</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (X) (this hospital) attended the deceased from May 9 19 68 to May 9 19 68, that (X) (we) last saw the deceased alive on May 9 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (30000) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>RH Twining M.D.</i>				<b>23B. DATE SIGNED</b> <b>5-10-68</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Raphl H. Twining M.D.</b>				<b>23D. ADDRESS</b> <b>3900 Loch Raven Blvd. Balto. Md. 21218</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>5-13-68</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Evergreen Cemetery</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Winston Salem, N.C.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 13 1968</b>			
<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Farley</i>		<b>25C. FUNERAL DIRECTOR</b> <b>Kelson F. H. 1348 N. Calhoun St.</b>			

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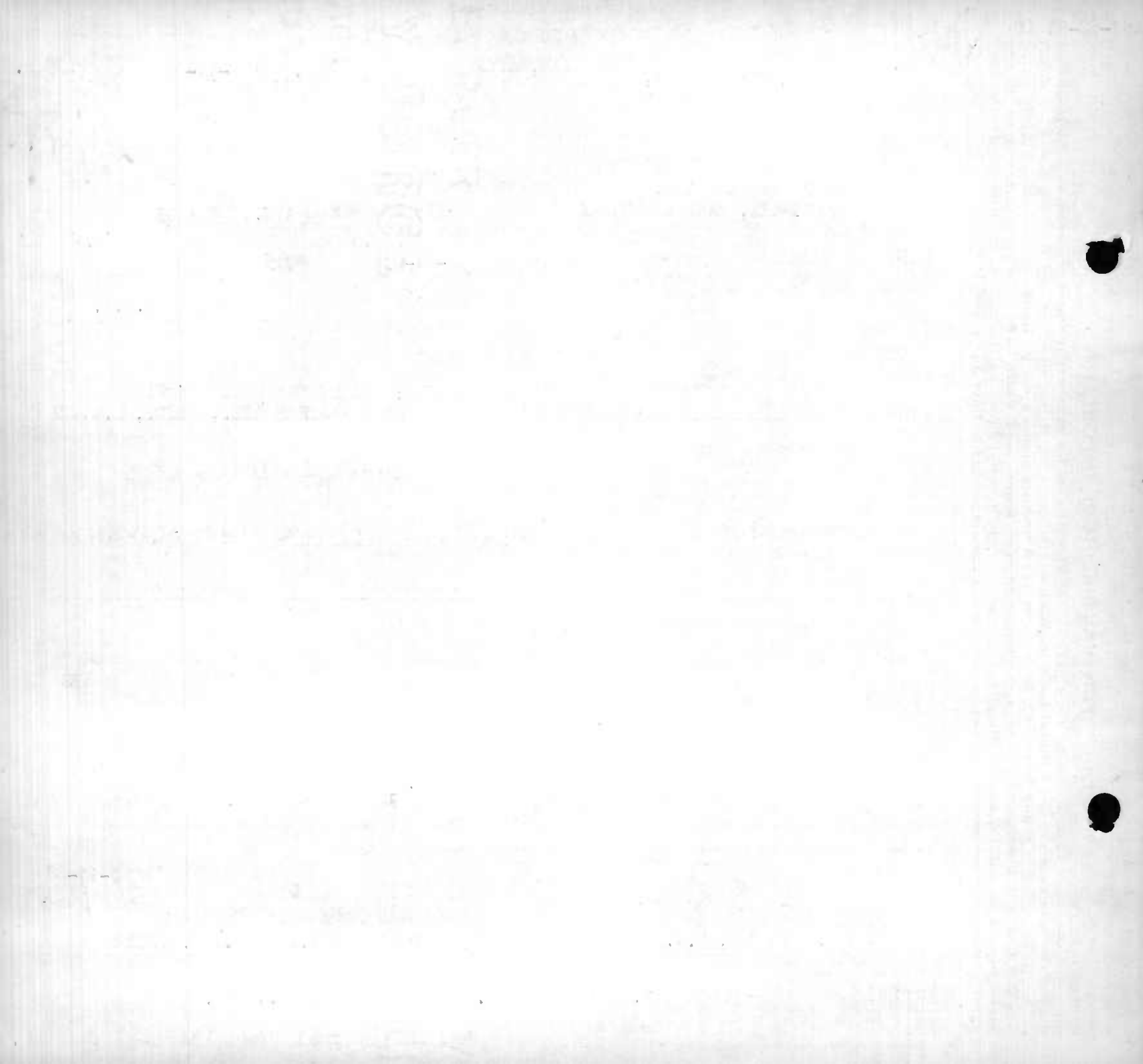
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

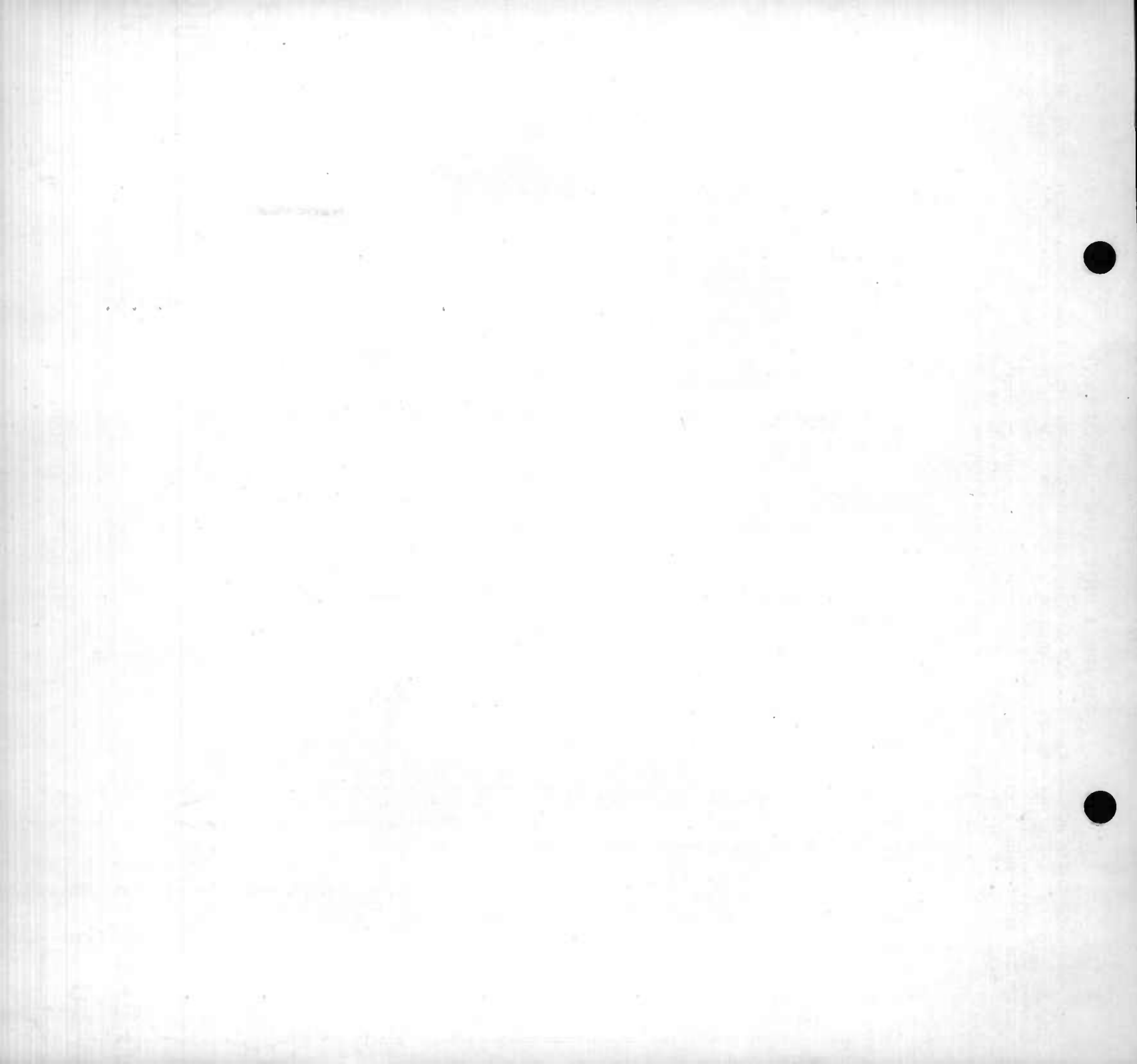
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-4968
W-32068-4968				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <b>WATTS, William</b>				2. DATE AND HOUR OF DEATH <b>5/11/68 7:35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE.</b> <b>BALTIMORE, MARYLAND 21224</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>4-22-03</b> 9. AGE (In years last birthday) <b>65</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>FLORIDA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ARTHUR</b>				14. MOTHER'S MAIDEN NAME <b>SUSIE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>266018254</b>	
17. INFORMANT <b>RECORDS: BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE., BALTO., MD. 21224</b>				ADDRESS	
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Embolus</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Metastatic Colonic Adenocarcinoma</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/1</b> 19 <b>68</b> to <b>5/11</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5/11</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Kay E. Gilmour, M.D.</b>				23B. DATE SIGNED <b>5-11-68</b> <b>5/11/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>KAY E. GILMOUR, M.D.</b>				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE., BALTO., MD. #21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>5-15-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>				24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Kelson Funeral Home</b>				ADDRESS <b>1348 Calhoun St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-4969	
BIRTH NO. <b>B-550</b>		68-4969		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>JOHN BOWMAN</b>			2. DATE AND HOUR OF DEATH <b>5. 10. 68</b> <b>12<sup>00</sup> NOON</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 LUTHERAN Hospital of Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2103 Herbert St.</b>		
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-2-03</b>	9. AGE (In years lost birthday) <b>65</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Willie Bowman</b>		14. MOTHER'S MAIDEN NAME <b>Bertie</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHART Eleanor Bowman</b> ADDRESS <b>same</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MYOCARDIAL INFARCTION, ATRIAL FIBRILLATION</b>  (B) <b>APCVD</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4. 9. 1968</b> to <b>5. 10. 1968</b> , that (I) (we) last saw the deceased alive on <b>5. 10. 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>P. Ariz</b> M.D. DEGREE				23B. DATE SIGNED <b>5. 10. 68</b>	
23C. PHYSICIAN'S NAME (Type) <b>P. Ariz</b> M.D. DEGREE				23D. ADDRESS <b>70 LUTHERAN Hospital, Balto, MD. 21216</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-14-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Rev. J. Kelson 1348 N. Calhoun St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-4970</u>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>Emma H. Vollerthum</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>May 11, 1968</u> M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <u>46 LUTHERAN HOSPITAL</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <u>Maryland</u> <b>B. COUNTY</b> <u>Baltimore Co.</u> <b>C. CITY OR TOWN</b> <u>Woodlawn</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>4 Summerfield Road # 21207</u>		
<b>5. SEX</b> <u>Female</u>	<b>6. RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5-28-1889</u>	<b>9. AGE</b> (In years last birthday) <u>78</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>At Home</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore, Md.</u>		
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
<b>13. FATHER'S NAME</b> <u>John Hoey</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Henrietta Graeser</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Olga Pue-Woodsboro, Md. 21798</u>
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Occlusion</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertension</u>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>acute</u> <u>years</u>
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <u>420.1 II</u>				
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>0</u>		<b>20A. AUTOPSY?</b> (Yes or No) <u>0</u>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>0</u>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <u>0</u>
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <u>0</u>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <u>0</u>
<b>22. I certify that (I) (this hospital) attended the deceased from <u>May 11 1968</u> to <u>May 11 1968</u>, that (I) last saw the deceased alive on <u>May 11 1968</u> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>C. J. Mendelis M.D.</u>				<b>23B. DATE SIGNED</b> <u>5/11/68</u>
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>C. J. Mendelis M.D.</u>				<b>23D. ADDRESS</b> <u>2308 Edmondson Ave Balto Md.</u>
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>5-14-68</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Woodlawn Cemetery</u>
<b>24D. LOCATION</b> (City, town, or county) <u>Baltimore, Maryland</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>MAY 13 1968</u>		
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Jones</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Ellsworth Armacost-4600 Liberty Hgts/</u>		

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE CENSUS

DATE

TIME

BY

NAME

ADDRESS

CITY

STATE

COUNTY

POST OFFICE

ZIP CODE

TELEPHONE

TELETYPE

TELEFAX

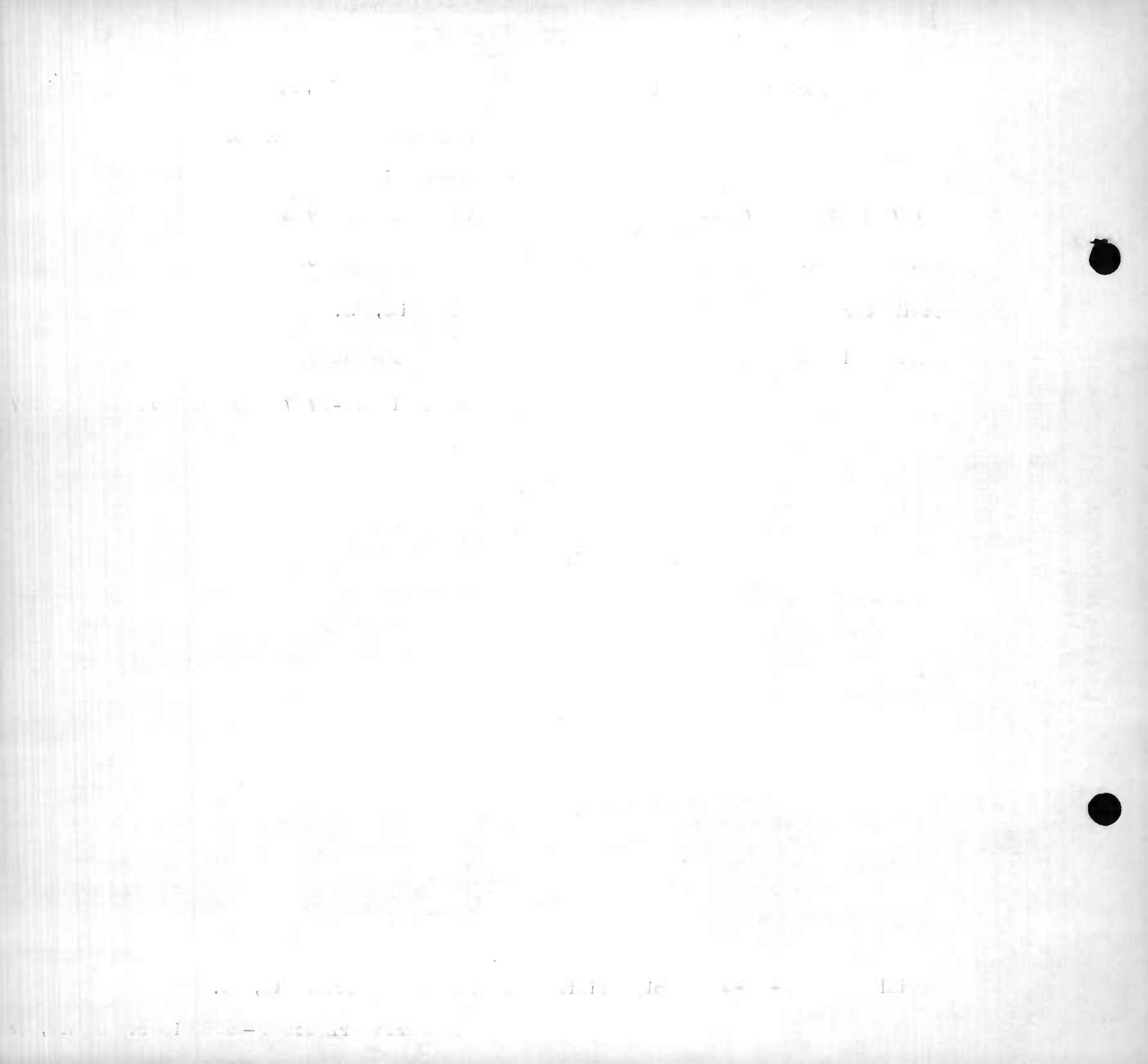
TELEVISION

**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-4971</b>
<b>7-260</b>		<b>68-4971 CERTIFICATE OF DEATH</b>		
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		<b>Charles Leo Fisher</b>		<b>May 10, 1968</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <b>00</b>		A. STATE <b>Maryland</b>		
		B. COUNTY <b>Baltimore</b>		
		C. CITY OR TOWN <b>Baltimore</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <b>3707 Marmon Avenue</b>		
5. SEX <b>Male</b>		6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>65</b>
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<b>Retail Store</b>		<b>Columbia, Pa.</b>		<b>USA</b>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
<b>Harry Fisher</b>		<b>Hohennadle</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
<b>NO</b>			<b>Norma Fisher-3707 Marmon Avenue # 21207</b>	
18. <b>412.4 I</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		<b>Cerebrovascular accident</b>		
ANTECEDENT CAUSES		(B) <b>ASCVD</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:		
		(C) <b>Myeloid metaplasia</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<b>0</b>			<b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from <b>5/17/57</b> 19 to <b>5/10/68</b> 19, that (I) (we) last saw the deceased alive on <b>5/4/68</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
<b>Joseph Shear</b>		<b>5/10/68</b>		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
<b>Joseph Shear M.D.</b>		<b>6715 PARK HEIGHTS</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
<b>Burial</b>		<b>5-14-68</b>	<b>Holy Trinity Cemetery</b>	<b>Columbia, Pa.</b>
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
<b>MAY 13 1968</b>		<b>Robert E. Fisher</b>		<b>Ellsworth Armacost 4600 Liberty Hgts, Ave</b>





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

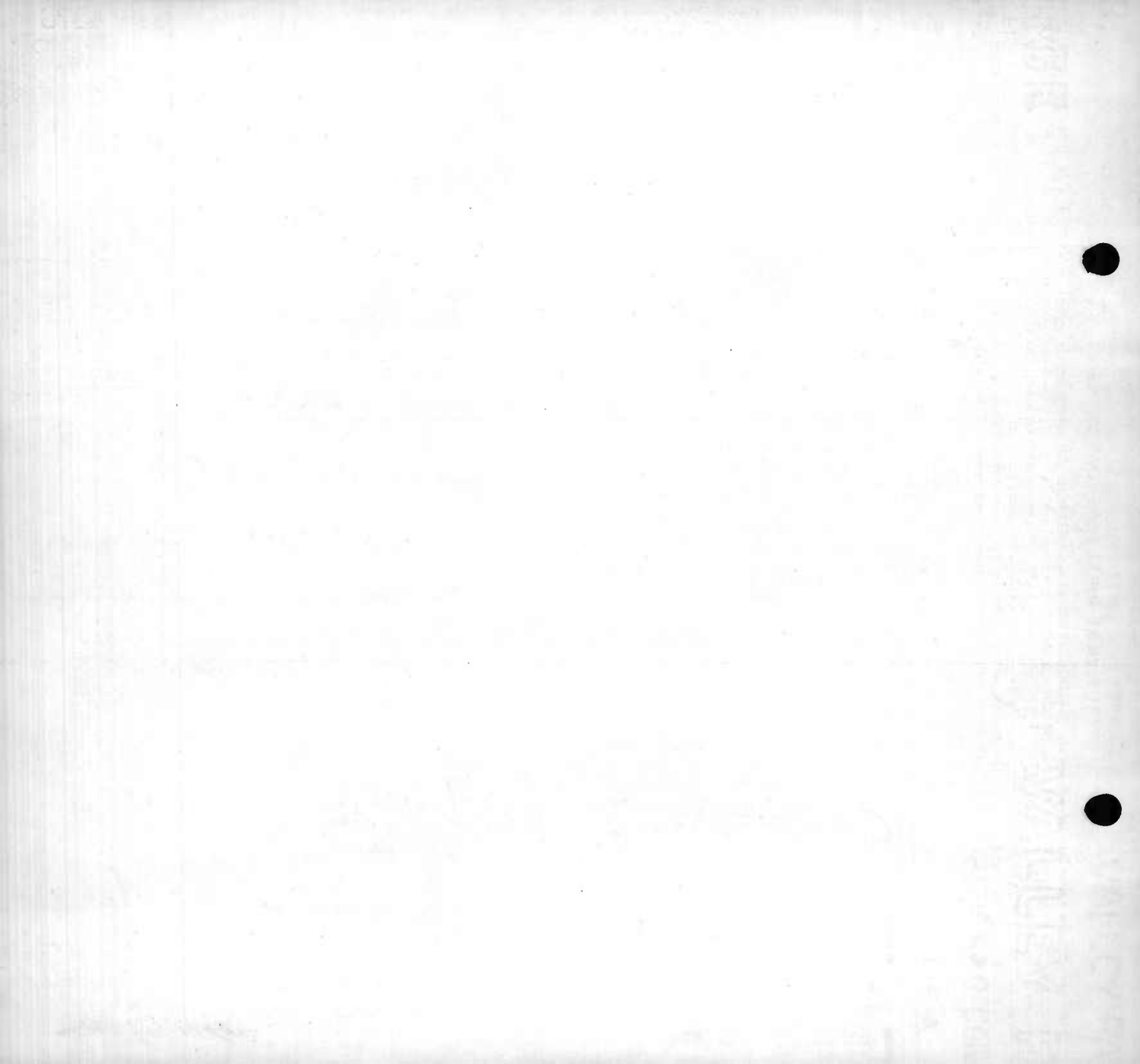
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4972	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 2em;">A-223</span> <span>68-4972</span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
GEORGE J. AUGUSTINE		May 11, 1968 10:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
HARFORD GARDEN'S CON. HOME		MARYLAND			
904700 HARFORD RD.		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2020 E. LOMBARD STREET			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1-25-1884	84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RET. BAKER		BAKING IND.		HUNGARY	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
U. S. A.		JOHN AUGUSTINE			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
TERESA PAWITSCH		NO			
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
25-07-0030		JOSEPH AUGUSTINE		6106 BERTRAM AVE	
				R1314	
18. 412.21		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		12 hours	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Acute pulmonary edema			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Acute myocardial failure			
		(C) Hypertensive C. V. disease			
443X II		Arteriosclerotic Sensitivity			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		No			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) <del>(the hospital)</del> attended the deceased from January 2 1968 to May 11, 1968, that (I) <del>(we)</del> last saw the deceased alive on May 11, 1968 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did)</del> (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
H. V. Harbold M.D.		May 13, 1968		H. V. HARBOLD M.D.	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
4706 HARFORD RD Baltimore Md		BURIAL		MAY 15 1968	
		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
		REDEEMER CEM.		BELAIR RD BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 13 1968		Robert E. Fisher		DIPPEL BROS. INC 1800 E LOMBARD ST	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <span style="border: 1px solid black; padding: 2px;">10</span>	68-- 4973
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Robert C. King</b>		2. DATE AND HOUR OF DEATH <b>5/12/68</b> <b>00<sup>10</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Maryland Gen. Hosp.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>20715P. Nech 66-00</b>		
			C. CITY OR TOWN <b>Bowie</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <b>12113 Lerner Place</b>		
5. SEX <b>♂</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/21/1917</b>	9. AGE (In years lost birthday) <b>50</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assoc. Adm.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hosp. MGH</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Horace King</b>			
14. MOTHER'S MAIDEN NAME <b>Rose Mc Kennhan</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>			
16. SOCIAL SECURITY NO. <b>203-01-2124</b>		17. INFORMANT ADDRESS <b>Florence King 12113 Lerner Pl. Bowie Md 20715</b>			
18. <b>150X I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac resp. arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Adenocarc. of esopha.</b>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. <b>150X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>04/05/68</b> 19 to <b>5/12/68</b> 19 that (I) <b>(we)</b> last saw the deceased alive on <b>5/12/68</b> 19 and that in my <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Ralph D. Raymond, MD</b>				23B. DATE SIGNED <b>5/12/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ralph D. REYMOND</b>				23D. ADDRESS <b>Maryland Gen. Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 15 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arlington National</b>	
24D. LOCATION <b>Arlington</b>		24E. (City, town, or county) (State) <b>Virginia</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL HOME <b>Howard County Funeral Home Harry Witzke</b>	
25D. ADDRESS <b>Ellicott City 21043</b>					



5-315

68- 4974

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4974

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Idella L. Stevenson</i>		2. DATE AND HOUR OF DEATH <i>May 9 1968 11<sup>15</sup> P.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>A.A.C. 52-00</i>		C. CITY OR TOWN <i>Glen Burnie</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Dec. 20, 1937</i>		9. AGE (In years last birthday) <i>30</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MAID</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>William L. Stevenson</i>	
14. MOTHER'S MAIDEN NAME <i>CORRINE Garrett</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Medical Record</i>		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Metastatic Carcinoma of Breast</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>July 1964 to May 9, 1968</i>	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 1, 1968</i> to <i>May 9, 1968</i> , that (I) (we) lost saw the deceased alive on <i>May 9, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Youngsik Moon M.D.</i>		23B. DATE SIGNED <i>May 9, 1968</i>		23C. PHYSICIAN'S NAME (Type) <i>Youngsik Moon M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/13/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Halls Menchum</i>	
24D. LOCATION (City, town, or county) <i>A.A.C. Md</i>		24E. LOCATION (State) <i>MD</i>		25A. DATE RECD BY HEALTH DEPT. <i>MAY 15 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Faulkner</i>		25C. FUNERAL DIRECTOR <i>108 W. Talbarn</i>		25D. ADDRESS <i>Robert E. Faulkner Montgomery</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-624				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4975				4			
BIRTH NO. 68-08468				68-4975				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) PRESLEY, <del>XXXXXX</del> Timothy Wayne								2. DATE AND HOUR OF DEATH MAY 8, 1968 9:15 A. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21061 B. COUNTY a.a.co 52-00							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVE BALTIMORE, MARYLAND 21227								C. CITY OR TOWN GLEN BURNIE				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 1317 HOWARD ROAD															
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05-6-68		9. AGE (In years last birthday) NB		If Under 1 Yr. Months: 2		If Under 24 Hrs. Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME RAY C. PRESLEY								14. MOTHER'S MAIDEN NAME SANDRA ELLEN ALLEMAN							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.				17. INFORMANT ST. AGNES HOSP. RECORD ROOM				ADDRESS			
18. 776.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Distress Sp. Pneumonia (B) Prematurity (C) 1				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 4 Fe			
19. 773.5 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).															
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (X) (this hospital) attended the deceased from MAY 6, 1968 to MAY 8, 1968, that (X) (we) last saw the deceased alive on MAY 8, 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.															
23A. SIGNATURE John K Weagly, MD								23B. DATE SIGNED 8 May 1968							
23C. PHYSICIAN'S NAME (Type) JOHN K WEAGLY, MD								23D. ADDRESS ST AGNES HOSPITAL-CATON & WILKENS AVE BALTO MD 21229							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 5-9-68		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery				24D. LOCATION (City, town, or county) (State) Balto., Md.					
25A. DATE RECD BY HEALTH DEPT MAY 13 1968				25B. NAME OF REGISTRAR Robert E. Tarkenton				25C. FUNERAL DIRECTOR Witzke Funeral Directors, Balto., Md. 21229				ADDRESS 4101 Edmondson Avenue			

XX

X

Y

R-1401

68- 4976

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4976

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rueppel, Albin Karl

2. DATE AND HOUR OF DEATH

5/9/68

11 30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Univ Hosp

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md. Balt.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4018 Walrad

5. SEX

M

6. RACE

W

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

8/11/14

9. AGE (In years  
last birthday)

53

If Under 1 Yr.

Months

Days

Hours

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Truckdriver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME

Karl

14. MOTHER'S MAIDEN NAME

Maria Ambrein

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unk

16. SOCIAL  
SECURITY NO.

212-18-9496

17. INFORMANT

(Wife)

Mrs. Theresa Rueppel

ADDRESS

4018 Walrad Av.

Baltimore, Md

18.

1985 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Respiratory Failure

(B)

Metastatic CA to Brain

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3 days

Yrs.

MEDICAL CERTIFICATION

193.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

1/4/26/68

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Br Tumor

20A. AUTOPSY

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

NO

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (nearly medical examined)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/17/68 19 to 5/9/68 19  
that (I) (we) last saw the deceased alive on 5/9/68 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

FK Cressman, Jr

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5/9/68

23C. PHYSICIAN'S  
NAME (Type)

DEGREE

23D. ADDRESS

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

May 18, 1968 Garden of Faith Cem.

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAY 13 1968

25B. NAME OF REGISTRAR

Robert E. Fairbanks

25C. FUNERAL DIRECTOR

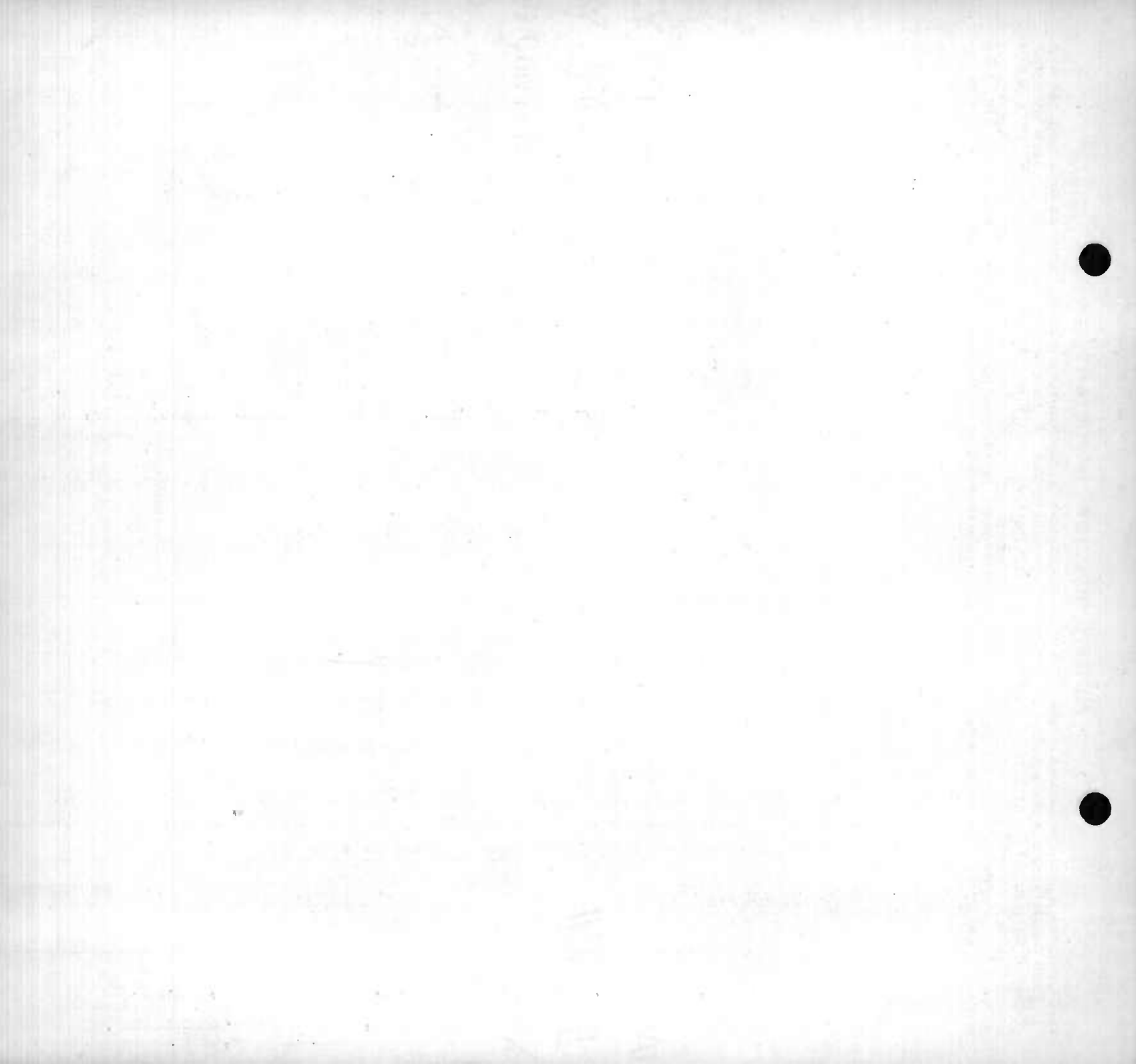
Witzke, 4101 Edmondson Ave.

ADDRESS

Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

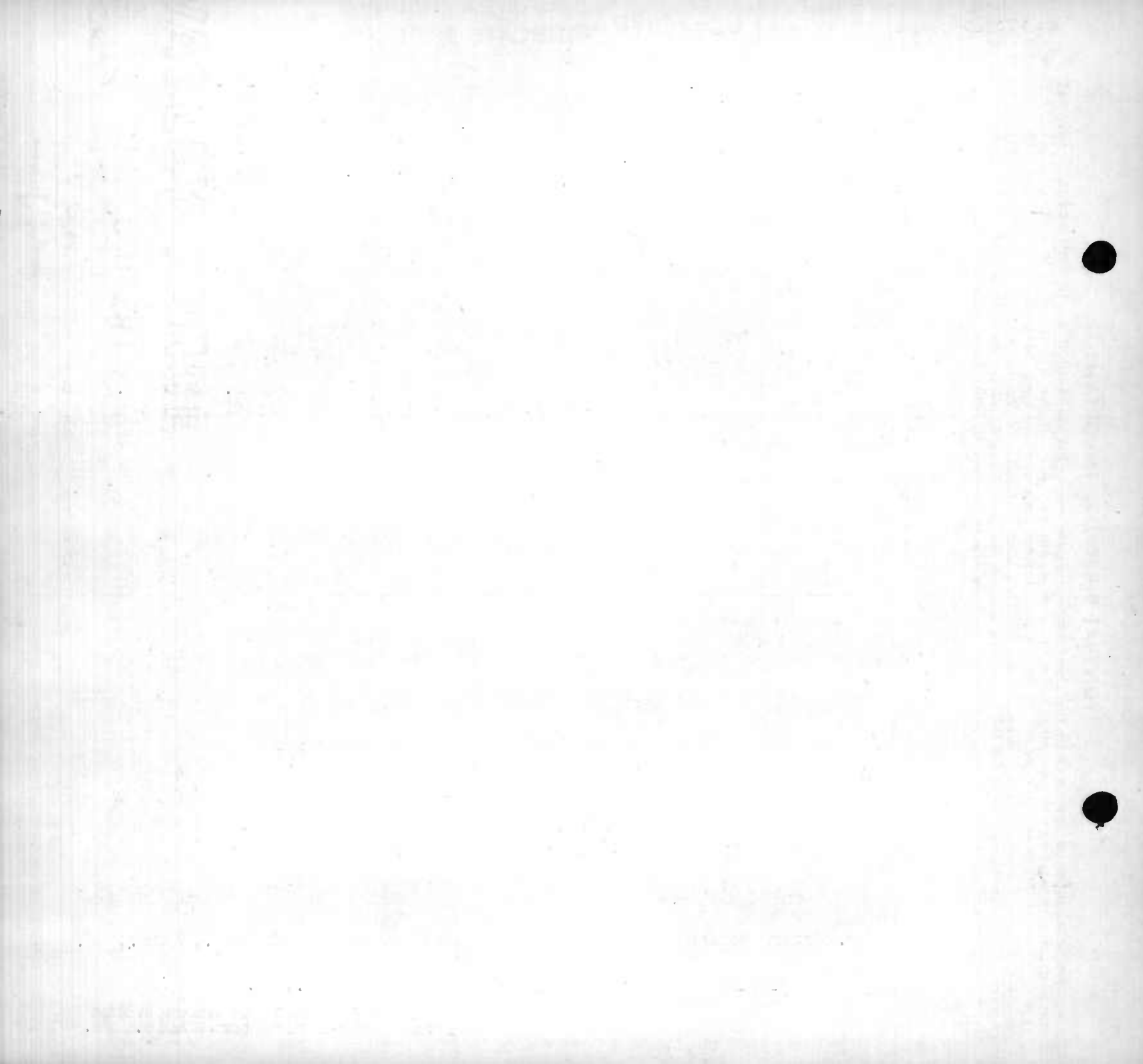
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68-4977	68-4977
CERTIFICATE OF DEATH				REG. NO.	68-4977
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Wenderoth, Howard B.		5-12-68 12:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
North Charles General Hospital			Maryland 21229		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			5104 Greenwich Avenue, Apt. B10		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/21/1900	67	retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William D. Wenderoth			Mary O'Brien		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		218-09-8173		NCGH chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			19. CAUSE OF DEATH		
412.41-199.0			CONGESTIVE HEART FAILURE		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			BARELY MATURE		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/11/68 19 to 5/12 1968, that (I) (we) last saw the deceased alive on 5/12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Arturo Norico				5-12-68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Arturo Norico		North Charles General Hosp., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	5-15-68	New Cathedral Cemetery		Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
				4101 Edmondson Avenue Witzke Funeral Directors, Balto., Md. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 4978 CERTIFICATE OF DEATH

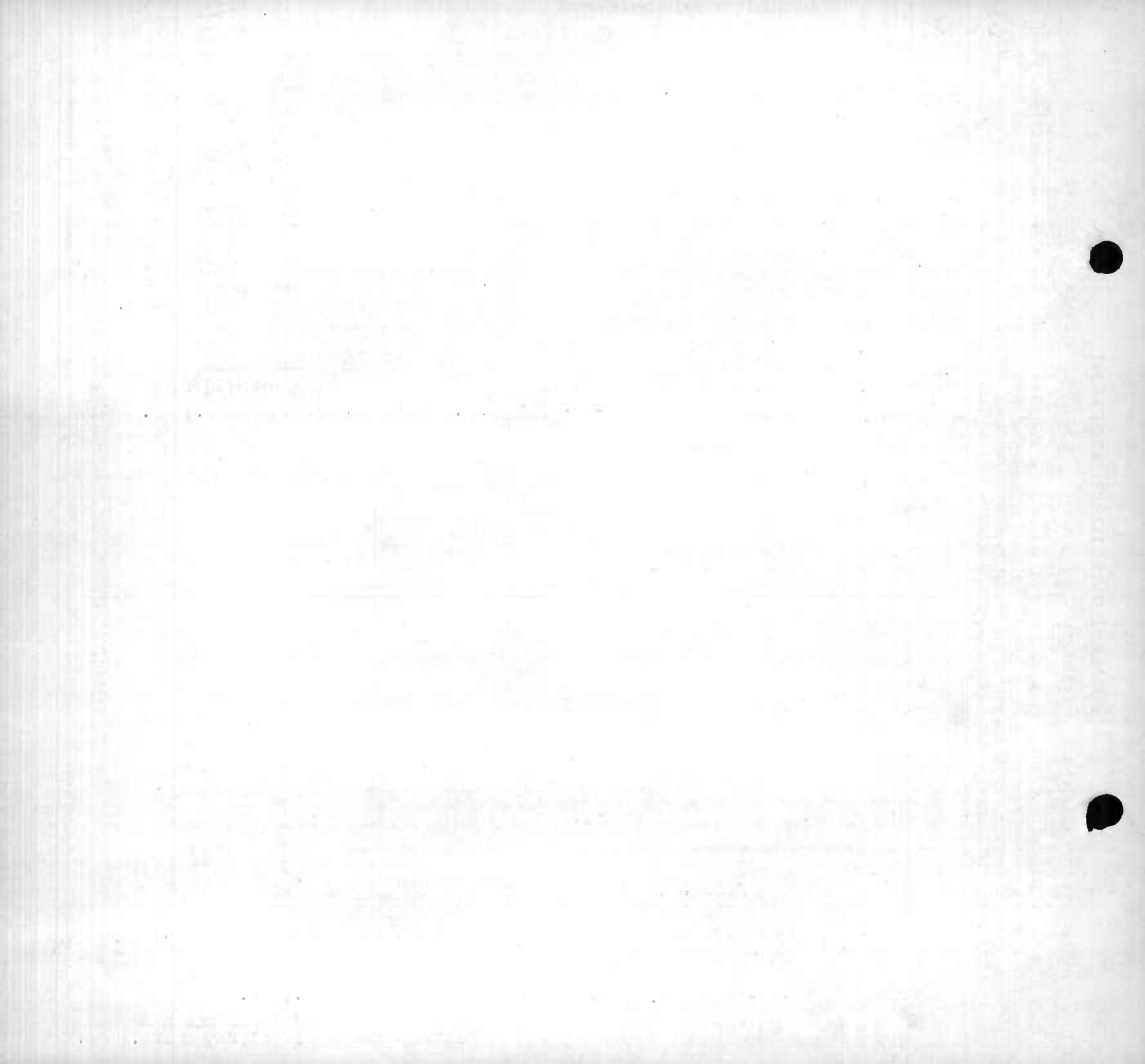
BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 4978

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MABEL LEAH WOODY</b>		2. DATE AND HOUR OF DEATH <b>5-9-68</b> <b>8:30 P.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>FRANKLIN SQUARE HOSPITAL</b>		E. STREET AND NUMBER <b>2701 Wilkens Ave</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-6-87</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>HARRY ECKMANN</b>		14. MOTHER'S MAIDEN NAME <b>KATIE WOODALL</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-18-9761</b>		17. INFORMANT <b>Mr. Edward Hastings, Balto., Md. 21207</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Congestive Heart failure</b> (B) <b>Atherosclerotic Cardiovascular Disease</b> (C) <b>Osteoarthritis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Osteoarthritis</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-1-68</b> 19 to <b>5-9-68</b> 19, that (I) (we) last saw the deceased alive on <b>5-9-68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Christina Abarrar-Feliciano, M.D.</b>		23B. DATE SIGNED <b>5-9-68</b>		23C. PHYSICIAN'S NAME (Type) <b>CHRISTINA ABARRAR-FELICIANO, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-13-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>R. B. E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Witzke Funeral</b>		25D. ADDRESS <b>4101 Edmonds Avenue</b>		25E. ADDRESS <b>Balto., Md. 21229</b>	





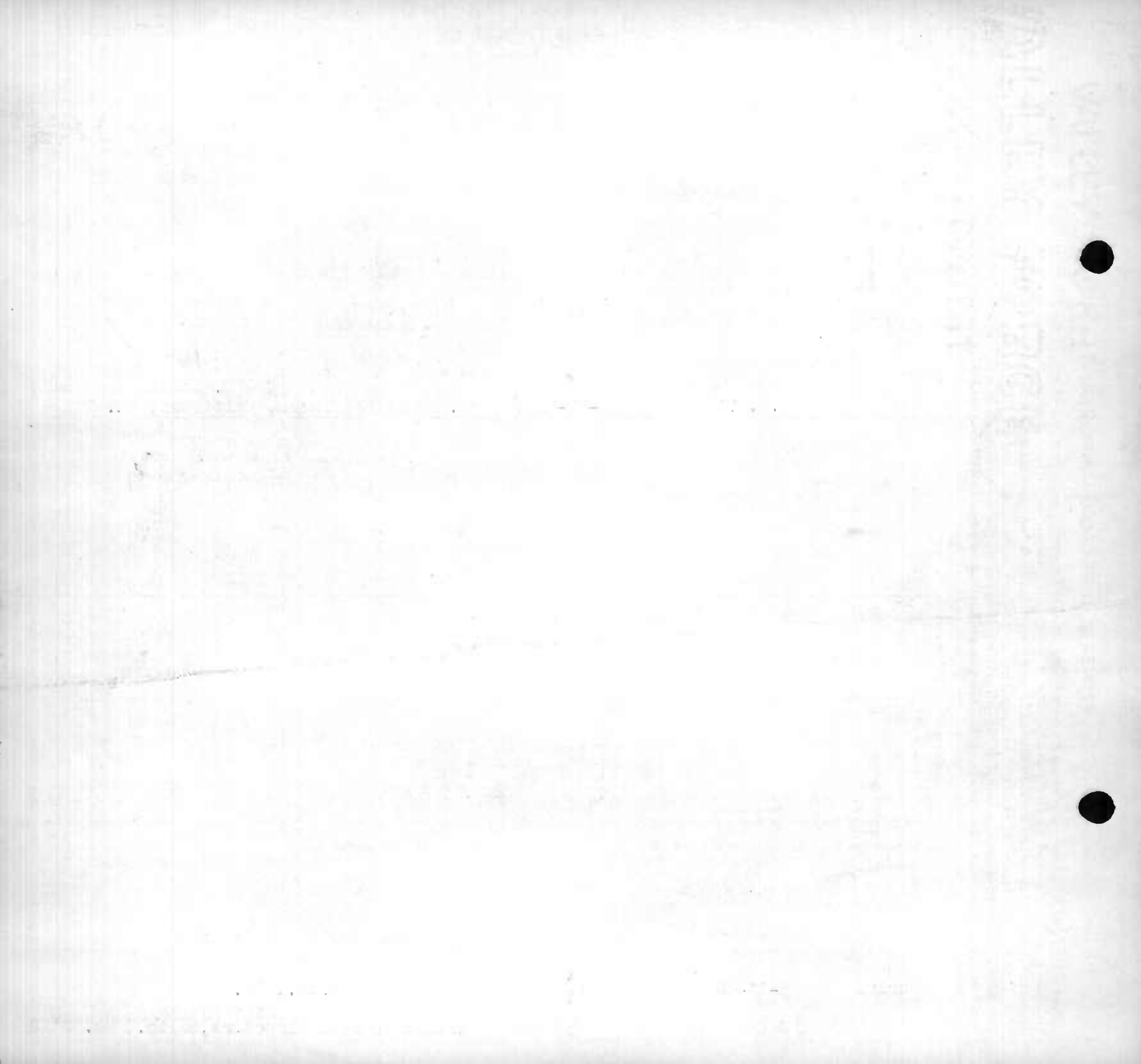
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4979

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

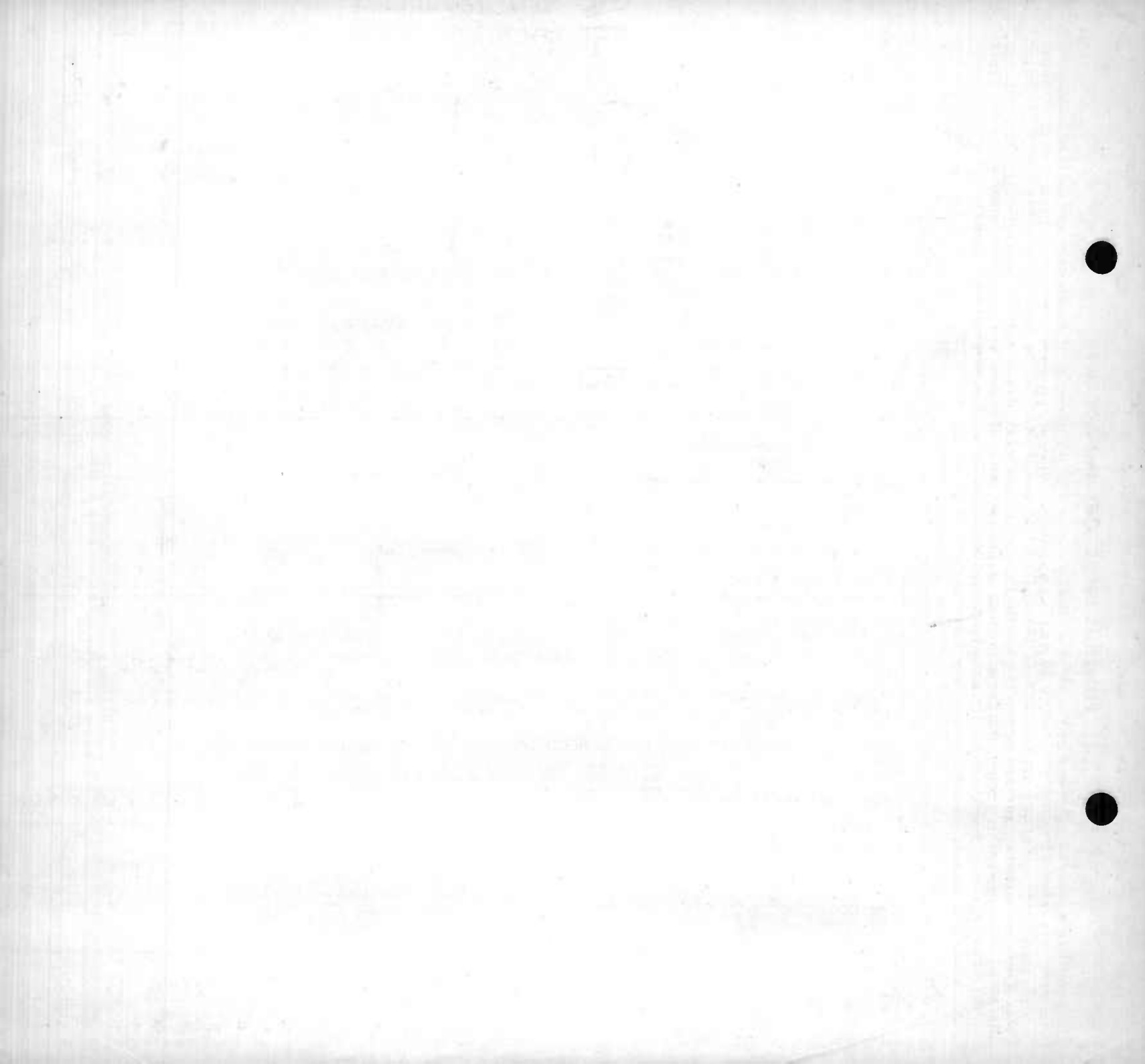
REG. NO. 68- 4979

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Ahern Edward C.</u>		2. DATE AND HOUR OF DEATH <u>5/8/68</u> <u>4</u> <sup>10</sup> <u>A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2804</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>		E. STREET AND NUMBER <u>4 N. Woodington Rd. Apt. E2</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-13</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>United Beauty Supply Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Patrick Ahern</u>		14. MOTHER'S MAIDEN NAME <u>Dora Kroll</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <u>W.W. 21</u>		16. SOCIAL SECURITY NO. <u>216-03-6467</u>		17. INFORMANT <u>Mrs. Sadie Mae Ahern, Baltimore, Md. 21229</u>	
18. <u>571.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Uremia &amp; liver failure</u> (B) <u>liver failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. <u>581.0</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/25/1968</u> to <u>5/8/1968</u> , that (I) (we) last saw the deceased alive on <u>5/8/1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. J. Hashemi M.D.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>M. J. HASHEMI M.D.</u>	
23D. ADDRESS <u>Bon Secours Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-11-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION <u>Bal to., Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>MAY 13 1968</u>			
24F. NAME OF REGISTRAR <u>Paul E. Taylor</u>		24G. FUNERAL DIRECTOR <u>Witzke Funeral Directors, Balto., Md. 21229</u>		24H. ADDRESS <u>4101 Edmondson Avenue</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-4980	
68-4980 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>AMBROSE GIRLIE PURNELL</b>		2. DATE AND HOUR OF DEATH <b>5-9-68 10 P.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>5-05</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>1846 N. Wolfe ST.</b>			C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M</b> 6. RACE <b>Negro</b>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/11/97</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HANDY MAN</b>			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>70</b>
13. FATHER'S NAME <b>Jacob PURNELL</b>			14. MOTHER'S MAIDEN NAME <b>Julia ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES AUG. 1918 - MAY 24, 1919</b>			16. SOCIAL SECURITY NO. <b>218-30-7144</b>		17. INFORMANT <b>MINNIE PURNELL</b>
18. <b>410.91x-250.9</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II</b>			(C) <b>Diabetes Mellitus.</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/25 1968</b> to <b>5/9 1968</b> , that (I) (we) last saw the deceased alive on <b>5/4 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John Thompson M.D.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/14/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO. NATIONAL</b>	
24D. LOCATION (City, town, or county) (State) <b>5500 FREDERICK AVE.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Joseph A. Rock</b>			
25D. ADDRESS <b>1304 N. Central Ave</b>					



FUNERAL DIRECTOR: IMPORTANT

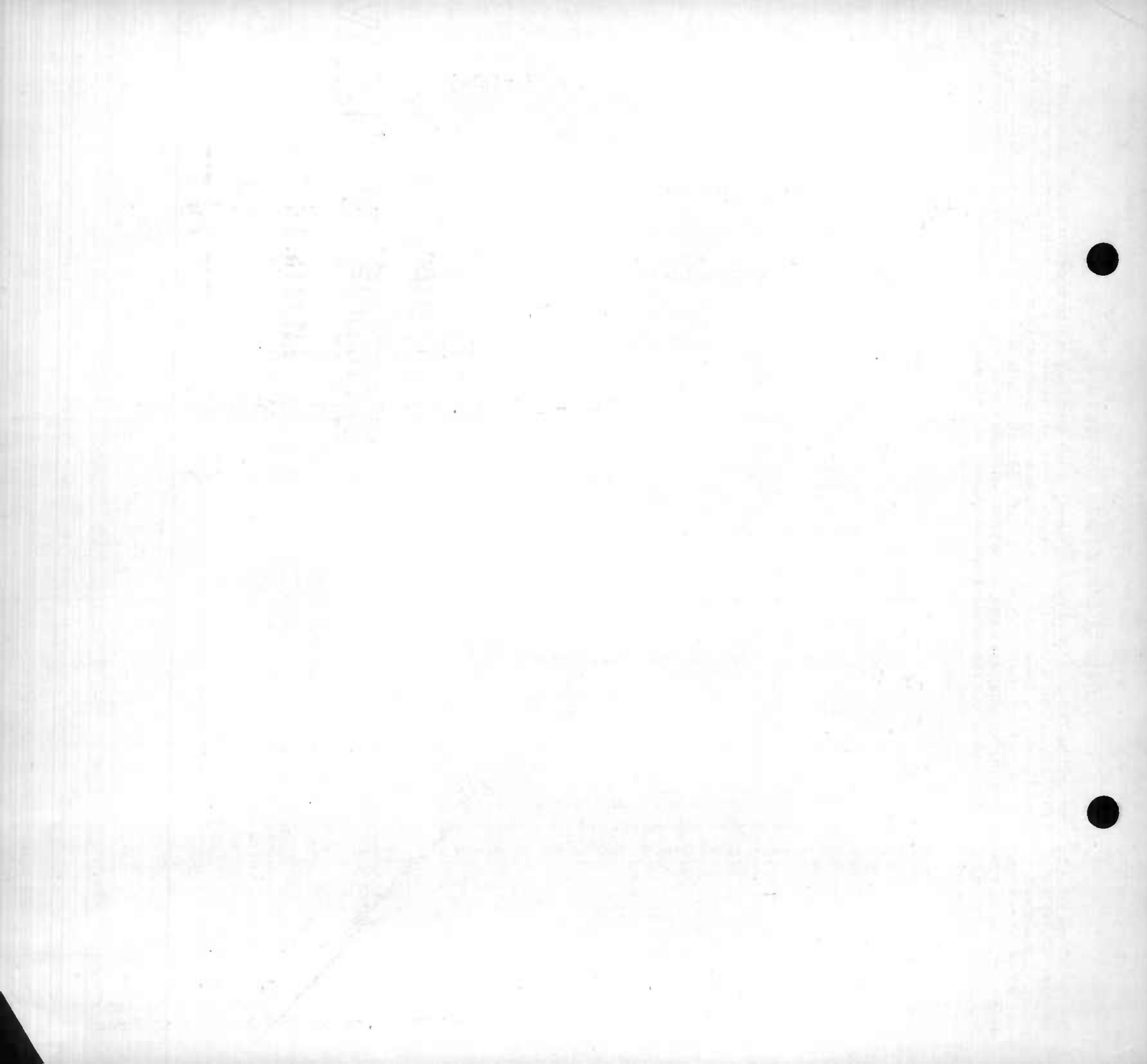
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4981

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4981

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>TWARDOWSKI, MRS. ALICE (Aniela)</b>		2. DATE AND HOUR OF DEATH <b>5/11/68</b>		510 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? <b>2- YES</b>	
E. STREET AND NUMBER <b>1933 Aliceanna STREET #31</b>							
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/8/98</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Food Packer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Booth Packing Co.</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>Poland</b>	
13. FATHER'S NAME <b>JOSEPH SCHAB John Schab</b>				14. MOTHER'S MAIDEN NAME <b>Agnieszka Agnes Kurdan</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-05-9294</b>		17. INFORMANT ADDRESS <b>Mrs. Theresa Coady 5536 Lanham Way 21206</b>			
18. <b>174 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>CA OF BREAST</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>170 X II</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>May 3</b> 19 <b>68</b> to <b>May 11</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>May 11</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Adrian V. Villarino</b> M.D. DEGREE				23B. DATE SIGNED <b>5-11-68</b>		23C. PHYSICIAN'S NAME (Type) <b>ADRIAN V. VILLARINO</b> M.D. DEGREE	
23D. ADDRESS <b>Bon Secours Hosp. Balto. Md.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/14/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George A. Weber 705 South Ann Street</b>			

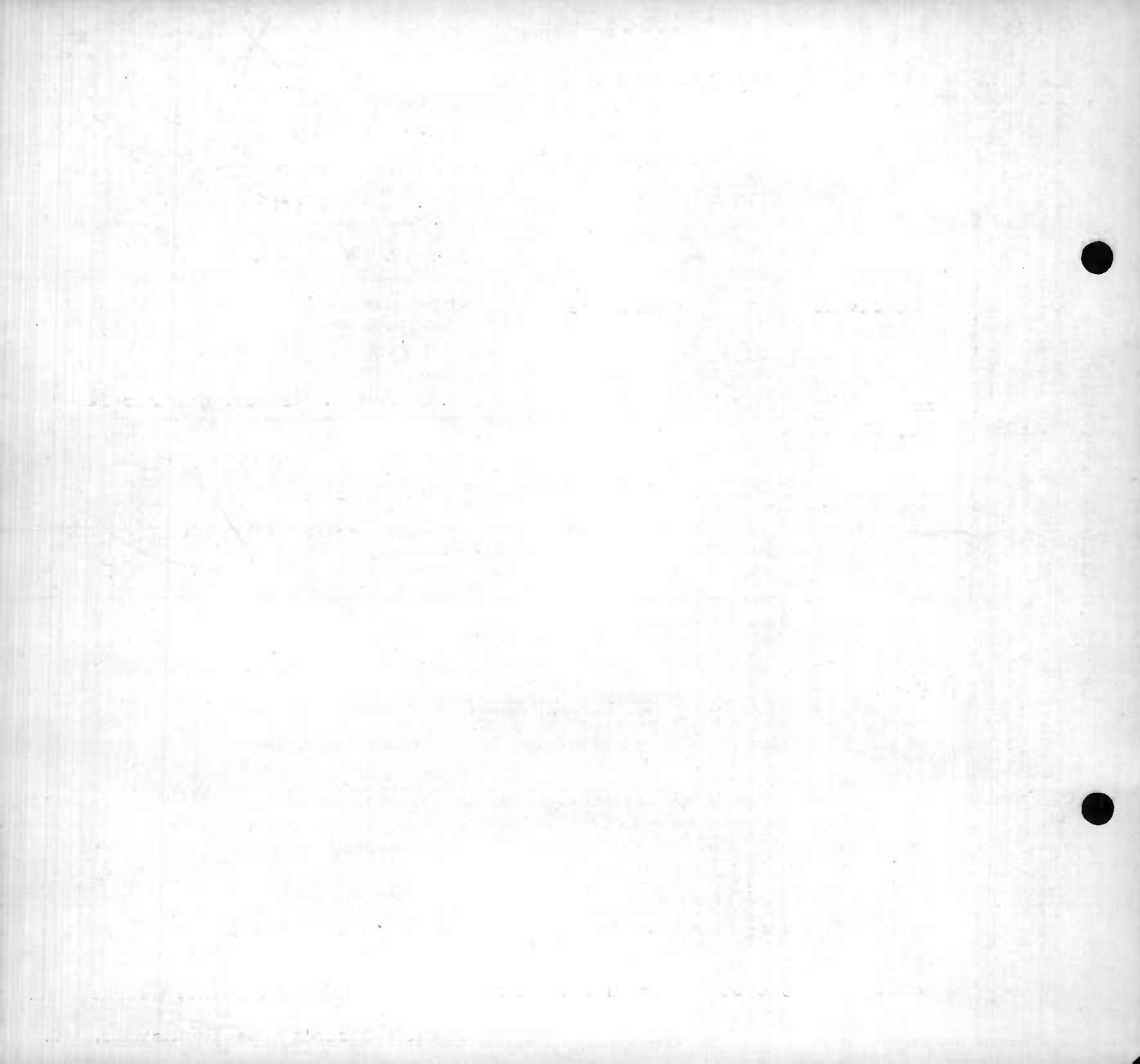




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-4982
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>VIVIAN HERBERT</b>		2. DATE AND HOUR OF DEATH <b>MAY 5 1968 12:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Prince Geo</b> <b>66-00</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MARYLAND</b> <b>38 HOSPITAL</b>			C. CITY OR TOWN <b>SEAT PLEASANT</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>3/9/12</b>		9. AGE (In years lost birthday) <b>56</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON D.C.</b>	
13. FATHER'S NAME <b>WILLIAM LONG</b>			14. MOTHER'S MAIDEN NAME <b>LOTTIE CROWELL</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-12-5230</b>		17. INFORMANT <b>Mr. Arthur E. Herbert Same as #4</b>	
18. <b>453 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY EMBOLISM</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ILIAC VEIN THROMBOSIS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b> <b>HOURS</b>		
19. DATE OF OPERATION <b>2</b>			20A. AUTOPSY? (Yes or No) <b>YES</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 4 1968</b> to <b>MAY 5 1968</b> , that (I) (we) last saw the deceased alive on <b>MAY 5 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles W. Harrison MD</b>			23B. DATE SIGNED <b>5/5/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>CHARLES W. HARRISON MD</b>			23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/8/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Washington National</b>	
24D. LOCATION <b>Suitland, Prince George Md.</b>		24E. NAME OF REGISTRAR <b>Robert E. Taylor</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4983 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

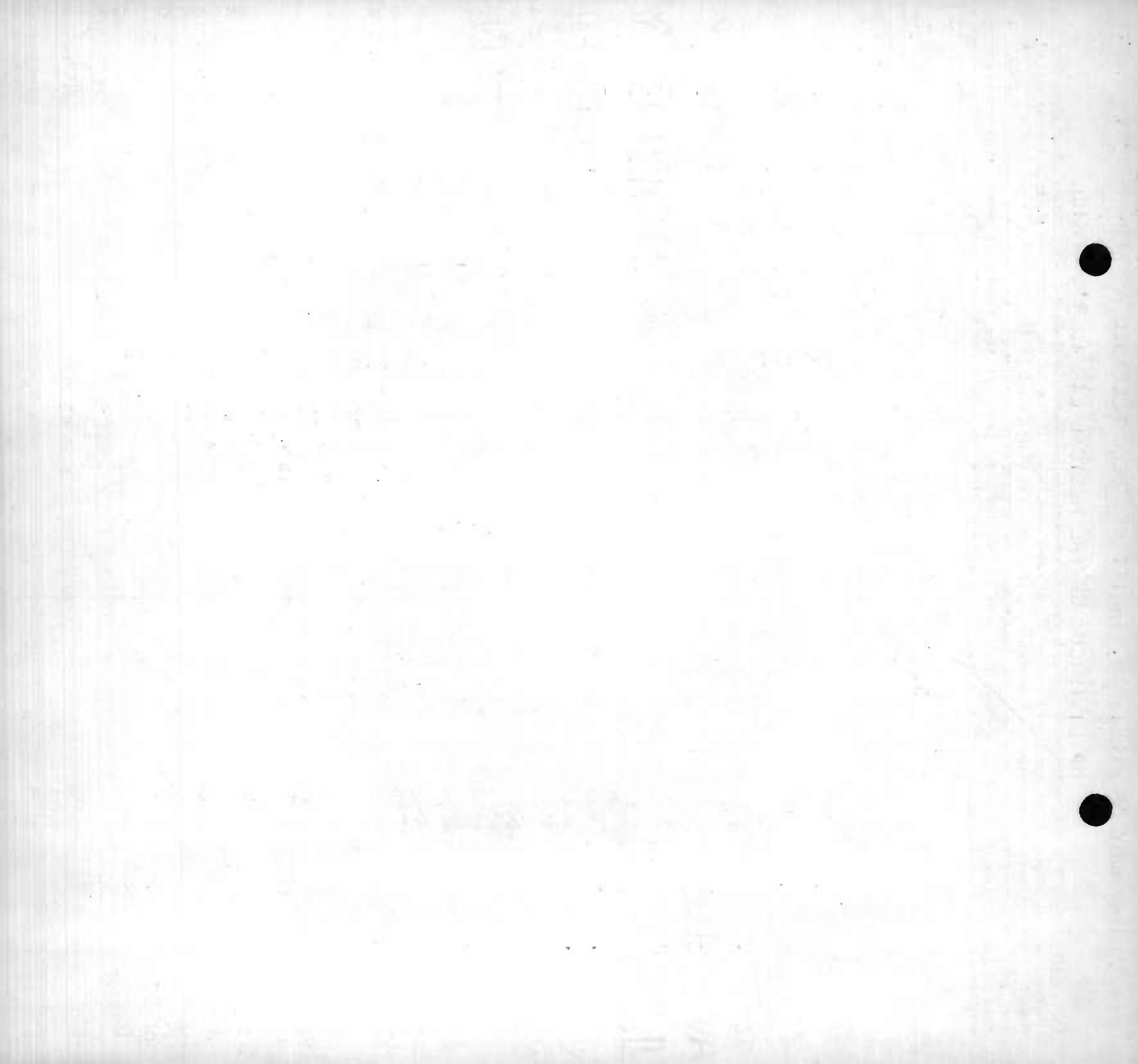
REG. NO. 68- 4983

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		VINCENT KRUG Sr.		May 10, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  00 2020 Grinnalds Avenue				A. STATE Maryland B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2020 Grinnalds Avenue	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1904		9. AGE (In years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Can Maker		10B. KIND OF BUSINESS OR INDUSTRY National Can		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Frank Krug			14. MOTHER'S MAIDEN NAME Barbara Schmidt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Anna Krug	
				ADDRESS 2020 Grinnalds Avenue	
18. 1621 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>metastatic carcinoma</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Cancer of Lung</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs 1 yr	
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>metastatic carcinoma</i>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/12 1965 to 5/10 1968, that (I) (we) last saw the deceased alive on 5/10 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Cliff Ratliff, Jr.</i>				23B. DATE SIGNED 5/13/68	
23C. PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.				23D. ADDRESS M.D. 4605 EDMONDSON AVE. BALTIMORE MD. 21239	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-14-1968		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
				24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 13 1968		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-613		68-4984		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-4984	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>WILLIAM H. THRIFT</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b> <b>BALTIMORE, MD 21205</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
5. SEX <b>MALE</b>				6. RACE <b>WHITE</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>7-29-08</b>			
9. AGE (In years lost birthday) <b>59</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>HENRY THRIFT</b>				14. MOTHER'S MAIDEN NAME <b>FANNIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>Coast Guard</b>				16. SOCIAL SECURITY NO. <b>216-03-8307</b>			
17. INFORMANT <b>Wm. Thrift, Jr</b>				ADDRESS <b>8065 Midhaven</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Acute Myocardial Infarction, Pulmonary Embolism or CVA</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASEVD</b>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
21. DATE OF OPERATION <b>4/22/11</b>				22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				24. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)			
25. TIME OF INJURY (Month) (Day) (Year) (Hour)				26. HOW DID INJURY OCCUR?			
27. I certify that (I) (this hospital) attended the deceased from <b>5/11/68</b> to <b>5/11/68</b> and that (we) last saw the deceased alive on <b>5/11/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
28. SIGNATURE <b>John R. Stone, MD</b>				29. DATE SIGNED <b>5/11/68</b>			
30. PHYSICIAN'S NAME (Type) <b>JOHN R. STONE M.D.</b>				31. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
32. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				33. DATE <b>5/14/68</b>			
34. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem.</b>				35. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
36. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>				37. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>			
38. FUNERAL DIRECTOR <b>Joseph J. Ziemann</b>				ADDRESS <b>163 S Conkling</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH			
300		68- 4985	
BIRTH NO.		REG. NO. 319648	
1. NAME OF DECEASED (Type or Print) <b>BEATRICE SCOTT</b>		2. DATE AND HOUR OF DEATH <b>5-10-68</b>   <b>11:40 AM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>CITY OF BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b>	
E. STREET AND NUMBER <b>1 131 EASTNORTH AVENUE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-20-99</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	9. AGE (In years lost birthday) <b>69</b>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Addison Brown</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Charles Scott</b>		ADDRESS <b>222 E. Lafayette Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>410.9 I</b>		CAUSE OF DEATH <b>Myocardial infarction</b>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCD</b>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A). <b>420.1 II</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5/9</b> 19 <b>68</b> to <b>5/10</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>5/10</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Allen B. Kaiser</b>		23B. DATE SIGNED <b>5/10/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Allen B. Kaiser</b>		23D. ADDRESS <b>JHH JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-14-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Randolph J. Collick</b>		ADDRESS <b>2431 E. Oliver St.</b>	



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4986	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MR. WILLIAM W. FRANKLIN</b>		2. DATE AND HOUR OF DEATH <b>2:50 AM. on 5/12/68 M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Md. Gen. Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto. Co.</b> <b>53-00</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <b>1807 E. Joppa Road</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/4/20</b>	9. AGE (In years last birthday) <b>47</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Excavation.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John Franklin</b>			
14. MOTHER'S MAIDEN NAME <b>Virginia Oaks.</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>214-12-9110</b>		17. INFORMANT <b>Mrs. Shirley M. Franklin</b>			
18. <b>446.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Obstructive lung Disease &amp; Uremia</b> <b>Periarteritis Nodosa</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION					
19. DATE OF OPERATION <b>456X II</b>					
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/22/1968</b> to <b>5/12/1968</b> , that (I) (we) last saw the deceased alive on <b>5/12/1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED <b>5/12</b>		23C. PHYSICIAN'S NAME (Type) <b>S. SWAROOP MD</b>	
23D. ADDRESS <b>Md. Gen. Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>5/15/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	

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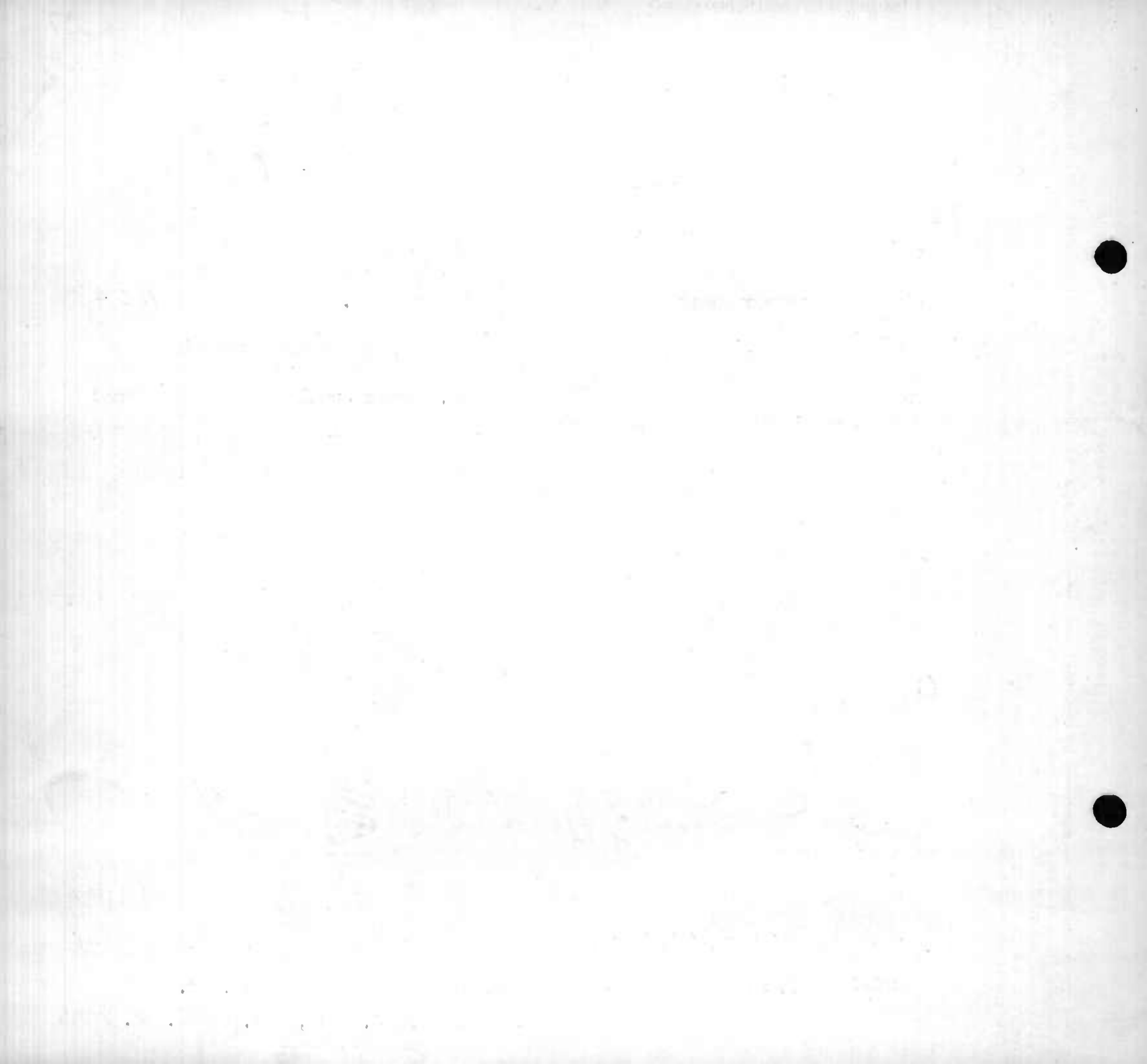
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-4987</u>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>John Boehl</u>		2. DATE AND HOUR OF DEATH <u>5/11/68</u> <u>2<sup>50</sup> P.</u> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland Gen. Hosp.</u>		C. CITY OR TOWN <u>Baltimore</u> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <u>1709 Homestead St.</u>		
5. SEX <u>♂</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/28/86</u>	9. AGE (In years lost birthday) <u>81</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mail <del>Book</del> Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Balt. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Jacob Boehl</u>		14. MOTHER'S MAIDEN NAME <u>Mary <del>Cooper</del> Huber</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 446369</u>	17. INFORMANT <u>Mrs. Bertha Boehl</u>	ADDRESS (Same)
18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardio-resp. arrest.</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>COAD, ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
19. <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>3/29/68</u> 19 to <u>5/11/68</u> 19, that (I) <u>(we)</u> last saw the deceased alive on <u>5/11/68</u> 19 and that in my <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.				
23A. SIGNATURE <u>Ralph D. Raymond M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <u>5/11/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ralph D. REYMOND</u>		23D. ADDRESS <u>Maryland Gen. Hospital.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5/15/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 13 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-4988

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-4988

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HA ROLD M. ROSE</b>		2. DATE AND HOUR OF DEATH <b>5/11/68 10<sup>55</sup> P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSP.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3409 ROYSTON AVENUE</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>04/15/1888</b>	9. AGE (In years lost birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Beth, Steel Co.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>CLAIR C. ROSE</b>			
14. MOTHER'S MAIDEN NAME <b>RACHAEL GRIFFITH</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>			
16. SOCIAL SECURITY NO. <b>213-07-3744</b>		17. INFORMANT <b>Mrs. ERNESTINE ROSE</b>			
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CVA</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>331X II</b>		(B) _____ (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>331X II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO.</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>March 18</u> 19 <u>68</u> to <u>May 11</u> 19 <u>68</u> . that (I) <u>(we)</u> last saw the deceased alive on <u>May 11</u> 19 <u>68</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <b>Enrique Cipriani M.D.</b>		23B. DATE SIGNED <b>5/11/68</b>		23C. PHYSICIAN NAME (Type) <b>ENRIQUE CIPRIANI MD.</b>	
23D. ADDRESS <b>33 and Calvert Sts</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/15/68.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	

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PENNSYLVANIA

RICHARD G. ELLIS

CLARK ROSS

and ERNESTINE ROSS

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4989

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOSEPH EDWARD MIGNINI

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

May

11,

1968

7:10 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

May

11,

1968

7:10 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore Co. 53-00

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

Aug. 22, 1941.

10. AGE (In years  
last birthday)

26

If Under 1 Yr. If Under 24 Hrs.

Months

Days

Hours

Min.

E. STREET AND NUMBER

2625 Perring Manor Road

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

Giacinto Mignini

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

American Import Trans. Employee

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

B. Marietta Salisbury

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No Yes Navy 1959.

17. SOCIAL SECURITY NO.

219-38-8400

18. INFORMANT

Mr. Giacinto Mignini

ADDRESS

19.

E812.0 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Craneo-Cerebral Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E816.4 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR? Moravia Road - 170 ft. S. of  
Supply Road22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

5/11/68

3:20 A.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Driver of car - in-  
volved in a head-on collision.

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/12/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5/16/68.

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 13 1968

25B. NAME OF REGISTRAR

Robert E. Falcione

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

WALLLEY & CO.

S-140

68- 4990

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4990

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MICHELLE LEE SHIPLEY</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>May 11, 1968 11:50 A.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sinai Hospital (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 11, 1968 11:50 A.M.</b>			
6. SEX <b>female</b>		7. RACE <b>white</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>March 2, 1944.</b>		10. AGE (In years last birthday) <b>24</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>1507-8600 Street 8504 Loch Raven Blvd.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>LeRoy Fountaine</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beorr Employee</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Helen D. Zanelotti</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-45-1103</b>		18. INFORMANT <b>Mrs. Helen Zanelotti</b>		ADDRESS <b>(Same)</b>	
19. <b>E8/2.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. <b>E8/16.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Johes Falls Expressway - 52 ft. S. of 4.4 mile marker</b>			
22D. TIME OF INJURY (APPROX.) <b>5/11/68 11:05 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Driver of car - struck in rear by mack truck.</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5/12/68</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/15/68.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbairn</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			

WALTERS

E-200

68-4991 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-4991

BIRTH NO. Pennsylvania

1. NAME OF DECEASED (Type or Print) <b>REBECCA KAY ESKEW</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <u>May</u> Day <u>11</u> Year <u>1968</u> Estimated <input type="checkbox"/> <u>May</u> <u>11</u> , 1968		Hour <u>11:10 A.</u>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u>		3. DATE PRONOUNCED DEAD Month <u>May</u> Day <u>11</u> Year <u>1968</u>		Hour <u>11:10 A.</u>
6. SEX <u>female</u>		7. RACE <u>white</u>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <u>March 28, 1968.</u>		10. AGE (In years lost birthday) <u>6 weeks</u>	If Under 1 Yr. If Under 24 Hrs. Months   Days   Hours   Min.	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Mr. Franklin M. Eskew</u>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <u>Joyce V. <del>Eskew</del> Jennings</u>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>None</u>		18. INFORMANT <u>Mr. Franklin M. Eskew</u>
19. <u>484X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Interstitial Pneumonitis SDII</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
3-25-X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>Yes</u>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz, M.D.</u> M.D. EXAMINER'S NAME (Type) DATE SIGNED <u>5/12/68</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/13/68.</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Cemetery</u>
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 13 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbairn</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>

X



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
68-4992				68-4992				68-4992			
M.E. CASE NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
(Type or Print)				Florence Hughes Carter				May 9th 1968			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				A. STATE			
FULL NAME OF HOSPITAL OR INSTITUTION				(If not in hospital or institution, give street address or location)				B. COUNTY			
6-19-68				Maryland				27-03			
606 N. Edgewood Street				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore			
D. STREET ADDRESS (If rural, give location)				2405 Montebello Terrace							
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. Under 1 Yr. Months Days	
Female		Colored		Widowed		Sept 26, 1875		92		10. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Teacher				Public Schools				Baltimore, Maryland			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
U.S.A.				James William Hughes				Mary Rebecca Lee			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
No				216-46-4171				Mrs. Courtney C. Valentine 2404 Montebell Ter.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				Anteroselectic Heart Disease							
ANTECEDENT CAUSES				(A) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO							
(C) DUE TO											
420.0 II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
								20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 5/5/68 to 5/8/68				and that (I) (we) lost saw the deceased alive on 5/8/68				and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED							
William M. Garner				3/12/68							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
WILLIAM M. GARNER				1005 W. Lafayette Ave							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME of CEMETERY or CREMATORY			
Burial				5/13/68				Arbutus Memorial Park			
24D. LOCATION				24E. LOCATION				24F. LOCATION			
Arbutus				Balto Co.				Md			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
MAY 13 1968				Herbert E. Nutter				3035 W. North Ave			



Statement from Physician

6-19-68 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-4993				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 68-4993	
1. NAME OF DECEASED (Type or Print) <b>CHARLES TORSELL</b>				2. DATE AND HOUR OF DEATH <b>5-7-68 6:35 A. M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL OF MD.</b> <b>46</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>22 JONES AVE.</b>					
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-12-18</b>		9. AGE (In years last birthday) <b>50</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MUSICIAN</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Catonsville MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Tosell</b>				14. MOTHER'S MAIDEN NAME <b>Priscilla Dorsey</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>220-09-4300</b>		17. INFORMANT ADDRESS <b>Mrs Louise E. Torsell 22 Jones Ave.</b>			
18. <b>161-9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiorespiratory Arrest</b> (B) <b>Severe Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Ruptured Aortic Aneurysm</b> <b>CH of Cora</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. <b>161X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <b>4-1-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CH of Lung</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1968</b> to <b>May 7, 1968</b> , that (I) (we) last saw the deceased alive on <b>May 7, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Arthur Pangilinan, M.D.</b>				23B. DATE SIGNED <b>May 7, 1968</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>ARTHUR PANGILINAN, M.D.</b>				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore CO. MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Torsell</b>		25C. FUNERAL DIRECTOR <b>Herbert E. Nutter</b>		ADDRESS <b>3035 W. North Ave.</b>			



A-53c

68-4994 BALTIMORE CITY HEALTH DEPARTMENT

68-4994

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM J. ANDERSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 5, 1968</b> Hour <b>9:26 A.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>716 North Gay Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 5, 1968</b> Hour <b>9:26 A.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>11/14/1940</b>		10. AGE (in years last birthday) <b>28</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Andrew Anderson</b>		14. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Jean Willabelle Stewart</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mr. Vural Oskay-201 Foster Knoll Drive Joppa Md.</b>	
19. <b>304.9 + 303.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Intravenous Narcotism</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20. DATE OF OPERATION <b>2</b>	
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute Ethylism</b>		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5-5-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fashy</b>	
25C. FUNERAL DIRECTOR <b>Herbert E. Nutter-3035 W. North Ave.</b>		ADDRESS	

WALTER

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4995

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH68- 4995  
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JAKUB SZACHNOWICZ</b>		2. DATE AND HOUR OF DEATH <b>MAY 13, 1968</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>			C. CITY OR TOWN <b>BALTO.</b> D. STREET AND NUMBER <b>133 S. LINWOOD AVE.</b>		
5. SEX <b>M</b>			6. RACE <b>White</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>OCT. 4, 1880</b>		
9. AGE (In years last birthday) <b>87</b>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>ANNA SZACHNOWICZ</b>			ADDRESS <b>133 S. LINWOOD AVE.</b>		
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anterolateral Myocardial Infarction</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF: Hypertensive C.V.D.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 7, 1968</b> to <b>May 13, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <b>Wladyslaw J. Jaworski</b>				23B. DATE SIGNED <b>5/13/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Wladyslaw J. Jaworski MD</b>				23D. ADDRESS <b>2711 Canton Ave</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/15/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Andrews Cem.</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE MD.</b>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jaworski</b>		25C. FUNERAL DIRECTOR <b>B. DABROWSKI</b>	
				ADDRESS <b>2818 E. BALTO. ST.</b>	

General Secretary  
International Chamber  
of Commerce

Meeting of Directors  
May 1924  
Page 10



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**CERTIFICATE AMENDED**  
5/11/68

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 4996	
68- 4996				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Teresa H. Gaudreau		May 11, 1968 9:40 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY		
6213 Blackburn Lane			Md.		
16. SOCIAL SECURITY NO.			C. CITY OR TOWN		
218-36-8138			Balto.		
E. STREET AND NUMBER			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
6213 Blackburn Lane					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W		11-12-1889	78	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Massachusetts	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Keating			Elizabeth Garritty		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218-36-8138		Lucien E.D. Gaudreau Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
422.1 II			Rheumatoid arthritis		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
					No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 10, 1968 to May 11, 1968, that (I) (we) last saw the deceased alive on May 10, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
F.J. Vollmer				May 13, 1968	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
F.J. Vollmer		6100 York Rd., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	5-14-68	New Cathedral		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
May 13 1968		H.W. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd.	

5/17/68- Correction farm.  
Lfr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4997	
BIRTH NO.		68-4997		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Alice Wenonah Roberts			May 12, 1968 9:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE 8. COUNTY		
Blackstone Apts. Charles & 33rd St.			Maryland Baltimore		
100			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			12-02		
Charles & 33rd Sts.					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10-12-1877	90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Executive		Canning		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Edwin G. Griffin			Alice Ann Ringrose		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		215-24-6110		Mrs. Muriel R. Seger	
				ADDRESS	
				Same	
18. 456X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Pneumonia. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hr.		
19. 493X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Generalized Cerebral A.S. 5 yr.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>we</del> ) attended the deceased from Jan 4 1966 to May 12 1968, that (I) ( <del>we</del> ) lost saw the deceased alive on May 12 1968 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE Norman R. Freeman				23B. DATE SIGNED 5/13/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				11 W. 29th St., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5-14-68		Druid Ridge	
				Pikesville Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 13 1968		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd.	

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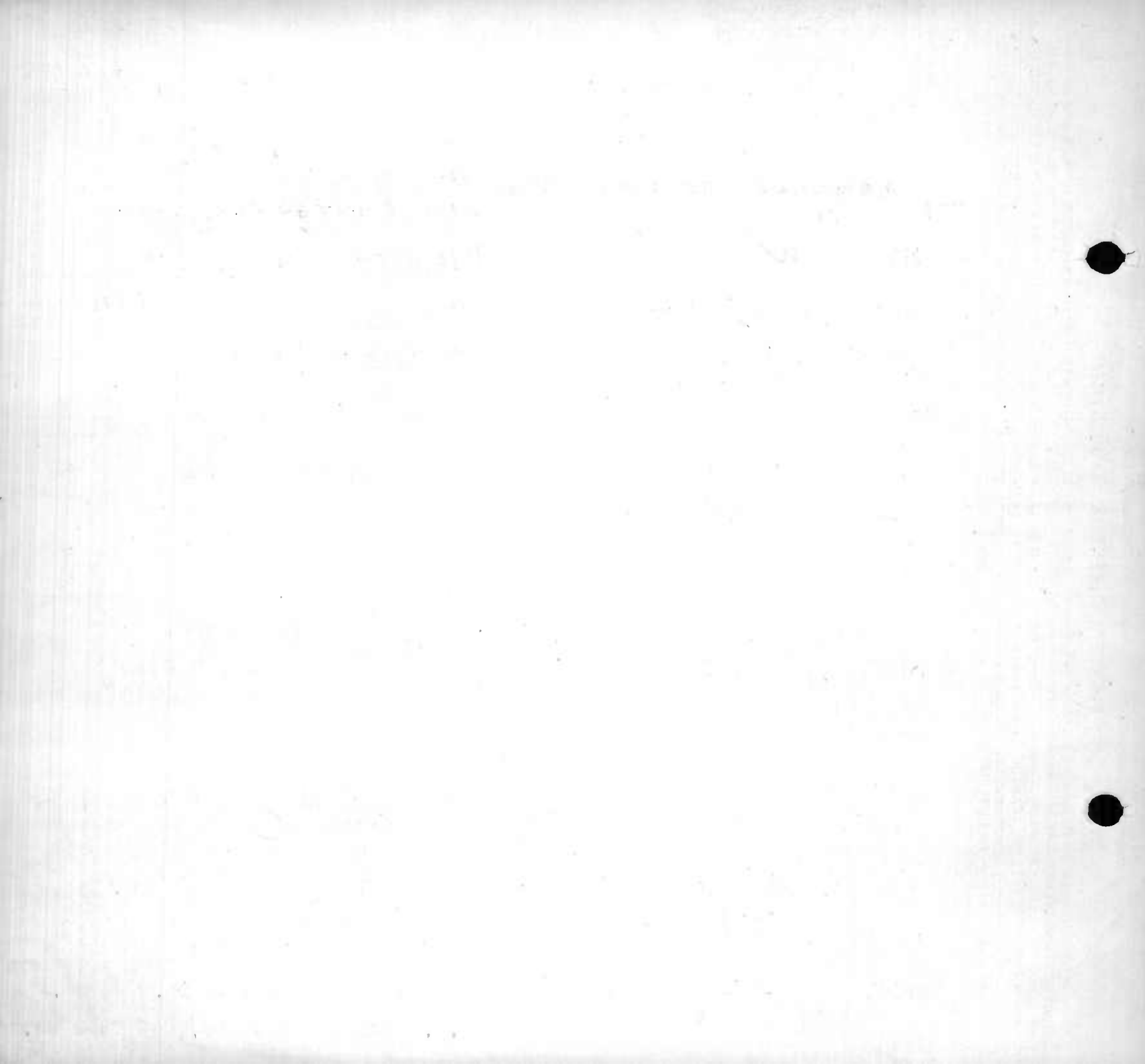
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-4998</u>	
68-4998				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>John W. Lohmuller</u>		2. DATE AND HOUR OF DEATH <u>5/12/68</u> <u>11:00</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>12-01</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 MARYLAND GENERAL HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE 21218</u> D. INSIDE-CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>W</u>		E. STREET AND NUMBER <u>3811 CANTERBURY ROAD</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-18-1880</u>		9. AGE (In years lost birthday) <u>87</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>DIETRICH LOHMULLER</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE DEPAPE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>138-01-2768</u>		17. INFORMANT <u>EURITH L. LOHMULLER</u> ADDRESS <u>ABOVE</u>	
18. <u>151X I</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>Carcinoma stomach</u>		<u>4 mos.</u>	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
151X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>CCF, ASCAD, pernicious anemia</u>		<u>Years</u>	
19A. DATE OF OPERATION <u>14/30/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>obstruction</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> 19 <u>68</u> to <u>5/12</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5/12</u> 19 <u>68</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>N. Bosch</u>				23B. DATE SIGNED <u>5/12/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Nicholas C Bosch</u>				23D. ADDRESS <u>Maryland General Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-15-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill</u>	
24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 13 1968</u>			
25B. NAME OF REGISTRAR <u>R. B. E. F. Jones</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd.</u>			



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68- 4999

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 4999

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RALPH O. SMITH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>May 12, 1968</b>		Hour <b>2:20 P.M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 12, 1968</b>		Hour <b>2:20 P.M.</b>
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY				
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
9. DATE OF BIRTH <b>6/13/1904</b>		10. AGE (In years lost birthday) <b>63</b>		E. STREET AND NUMBER <b>207 Kemble Road</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William Francis Smith</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ships Attendant</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Maritime</b>		15. MOTHER'S MAIDEN NAME <b>Lelia R. Weishample</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>123-10-8356</b>		18. INFORMANT <b>Mary Kathryn H. Smith</b>
19. <b>E 881 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Craniocerebral Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		ADDRESS <b>Above</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>207 Kemble Road 12-01</b>
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>May 11, 1968 ?</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject fell from ladder</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>5-13-68</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-16-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn</b>
24D. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>
				ADDRESS <b>4905 York Rd.</b>



Paul Walker

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DANIEL T. POSTON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>5 9 68 7:00 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 adjacent 6400 blk. Hillen Road</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 9, 1968 7:00 p.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
10. AGE (In years lost birthday) <b>30 29</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		E. STREET AND NUMBER <b>2126 Corbin Road</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Daniel T Poston Jr.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Lord Balto. Press</b>	
15. MOTHER'S MAIDEN NAME <b>Mary Louise Dooley</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1956 1959</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Ann Poston</b>	
19. CAUSE OF DEATH <b>E 9601 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>E 987X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Park</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Mt. Pleasant Park - 6400 Hillen Rd.</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <b>5 9 68 6:30</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject shot during argument</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>May 10, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/13/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial Pk</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Edwards</b>	
25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc.</b>		ADDRESS <b>Baltimore, Md</b>	

United States of America

U.S. Department of Justice

Washington, D.C.

*Handwritten signature*